STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G204	A. BUILDING _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	**185 MARTINDALE RD 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 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure specific objectives necessary to meet the needs of 1 of 6 clients (#3). The finding is: Observations throughout the 6/6-7/23 survey revealed client #3 to frequently invade the personal space of others in the home, as well as grab and pull the surveyors and staff by the wrist and around the waist. Continued observation during the dinner meal on 6/6/23 revealed client #3 to grab and drink client #6's beverage. Further observations upon exiting the home on 6/6/23 revealed client #3 to follow the surveyor outside and grab the surveyor, preventing them from entering their car. Subsequent observations throughout the survey revealed staff to verbally redirect client #3 by saying "stop," "no," or "space." Review of client #3's record on 6/7/23 revealed an individual habilitation plan (IHP) dated 9/29/22. Review of the IHP indicated training goals to brush teeth with assistance, shower with 2 verbal prompts, wash his face for 10% of trials, wash his hands for 10% of trials, clean his area during leisure time for 10% of trials, put groceries in the grocery cart twice a month for 10% of trials, clean his place after sitting after dinner with verbal prompt for 10% of trials, and engage in physical activity for a minimum of 30 minutes for no less than 3 times a week with 10% independence.	W 227		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G204	A. BUILDING _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	185 MARTINDALE RD 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 227	Continued From page 1 Continued review of client #3's record revealed a behavior support plan (BSP) dated 4/7/23. Review of the BSP indicated target behaviors to include self-injurious behavior, aggression, property destruction/misuse, agitation, disrobing, and elopement. Interview with the qualified intellectual disabilities professional (QIDP) on 6/7/23 revealed client #3 displays continuous behaviors related to boundaries and personal space. Continued interview with the QIDP revealed the interdisciplinary team has not formally addressed client #3's behaviors related to boundaries and personal space.	W 227		
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 1 of 6 clients (#3) received a continuous active treatment program consisting of needed interventions as identified in the behavior support plan (BSP). The finding is: Observation throughout the 6/6-7/23 survey	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G204	A. BUILDING _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	185 MARTINDALE RD 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	W 249		

revealed client #3 to engage in various behaviors, to include invading personal space, grabbing staff and surveyors, disrobing in the common area, rectal/groin digging, food and drink seeking, and grabbing table food and drink from other clients. Continued observation on 6/7/23 at 7:58 AM revealed client #3 to exit the common area unsupervised. Further observations throughout the survey revealed staff to verbally prompt client #3 with "stop," "no," or "space."

Review of client #3's record on 6/7/23 revealed a BSP dated 4/7/23. Review of the BSP indicated target behaviors to include self-injurious behavior, aggression, property destruction/misuse, agitation, disrobing, and elopement. Continued review of the BSP indicated client #3 requires 1:1 assigned staff supervision and constant visual monitoring within arms-length to prevent or manage problem behaviors of concern. Further review of the BSP indicated client #3 may sit in a separate area during mealtime to prevent taking food served or belongings of others. Additional review of the BSP indicated recommendations for the refrigerator and pantry to be locked to prevent food seeking, and a one-piece leotard under his clothes to help prevent disrobing or rectal/groin digging or scratching. Continued review of client #3's record revealed a team meeting note dated 5/1/23 which indicated the client's mother provided verbal consent to the BSP.

Interview with staff J on 6/7/23 revealed there is not a specific staff assignment to provide 1:1 supervision for client #3, rather it's whomever he cling's himself too and we all take turns. Interview with the qualified intellectual disabilities professional (QIDP) on 6/7/23 confirmed the interdisciplinary team met in May and client #3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G204	A. BUILDING _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	185 MARTINDALE RD 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 3 mother provided verbal consent to the BSP. Continued interview with the QIDP revealed staff have not been trained on the client's BSP and it is not currently being implemented. Further interview with the QIDP revealed staff are to complete a form to identify who is responsible for providing the client's 1:1 supervision each shift.	W 249		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the individual habilitation plan (IHP) was revised at least annually for 1 of 3 audited clients (#6). The finding is: Review of records on 6/6/23 for client #6 revealed an IHP dated 2/4/22. There was no additional documentation provided to show evidence that client #6's IHP meeting had taken place and updated since 2/4/22. Interview on 6/6/23 with the qualified intellectual disability professional (QIDP) confirmed that client #6's current plan is dated 2/4/22. Continued interview with the QIDP revealed that due to guardian participation the IHP meeting had not taken place.	W 260		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G204	A. BUILDING _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	185 MARTINDALE RD 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 371	Continued From page 4	W 371		

is an appropriate objective, and if the physician does not specify otherwise.
This STANDARD is not met as evidenced by:
Based on observation, record review and interviews, the system for drug administration failed to assure 2 of 2 clients (#1 and #4) observed during medication administration were provided the opportunity to participate in medication self-administration or provided teaching related to name, purpose and side effects of medication administered. The findings are:

A. The system for drug administration failed to assure client #1 was provided the opportunity to participate in medication self-administration. For example:

Observation in the group home 6/7/23 at 8:09 AM revealed staff B to have pre-punched medications for administering to client #1 into a medication cup. Continued observation revealed client #1 to enter the medication room, walk pass staff B and pick up medication cup containing all medications, the client to take all medications with water and the client to exit the medication room. Client #1 was not observed to receive any training during medication pass or to participate beyond taking medications left sitting on medication cart and drinking water.

Review of records on 6/7/23 for client #1 revealed an individual habilitation plan (IHP) dated 1/19/23. Continued review of the IHP revealed that client #1 needs assistance to self-medicate, however recognizes one of the medications he takes and knows the name of it. Additionally, the client has self-administration of medication services goals in place to retain his level of independence when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G204	A. BUILDING _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	185 MARTINDALE RD 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 371	Continued From page 5 taking his oral pill and applying his oral rinse. Interview with staff B on 6/7/23 revealed that staff B usually punches all medications into medicine cup and then calls client into medication room to take medicine with water. Continued interview with staff B revealed that she did not educate or train clients during medication administration; however, she usually would provide education. Interview with the qualified intellectual disability professional (QIDP) on 6/7/23 verified that staff should train and educate all clients during medication administration. Continued interview with the QIDP revealed that clients should participate in medication administration. B. The system for drug administration failed to assure client #4 was provided the opportunity to participate in medication self-administration. For example: Observation in the group home 6/7/23 at 8:11 AM revealed staff B to have pre-punched medications for administering to client #4 into a medication cup. Continued observation at 8:15 AM revealed client #4 to enter the medication room, to pour water and to take all medications whole with water. Further observation revealed staff B obtained ear drops for client #4 from the cabinet, staff B to apply 4 drops to both ears and the client to exit the medication room. Client #4 was not observed to receive any training during medication pass or to participate beyond taking medications left sitting on medication cart and drinking water poured by client. Review of records for client #4 revealed an IHP dated 6/1722. Continued review of IHP revealed that client #4 participates in service goals to	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G204	A. BUILDING _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON SMITH COTTAGE	185 MARTINDALE RD 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 371	Continued From page 6 self-medicate with staff's assistance as needed. Interview with staff B on 6/7/23 revealed that staff B usually punches all medications into medicine cup and then calls client into medication room to take medicine with water. Continued interview with staff B revealed that she did not educate or train clients during medication administration; however, she usually would provide education. Interview with the qualified intellectual disability professional (QIDP) on 6/7/23 verified that staff should train and educate all clients during medication administration. Continued interview with the QIDP revealed that clients should participate in medication administration.	W 371		