STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G277	A. BUILDING ______ B. WING ______	R 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASON STREET	**306 N MASON STREET** **APEX, NC 27502**

(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 000	INITIAL COMMENTS A revisit was conducted on September 11, 2023 for all previous deficiencies cited on July 12, 2023. The following deficiency was corrected, W249. The facility remained out of compliance in W369.	W 000		
{W 369}	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 2 of 4 audit clients (#4 and #5) received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of meal guidelines to promote safe eating. The findings are: A. During dinner observations at a restaurant on 7/11/23 at 6:00 pm, the Home Manager (HM) sat next to client #4. Client #4 ordered a cheeseburger sandwich for dinner. Client #4 was observed taking quick bites from his burger, overstuffing his mouth. There were no observations of staff at the table, prompting client #4 to slow his eating pace. Client #4 finished his meal, without incident. Review on 7/11/23 of the nutritional evaluation from 10/18/22 revealed client #4 was on a regular diet and should eat bite size pieces at a safe rate. B. During dinner observations at a restaurant on 7/11/23 at 6:00 pm, revealed client #5 ordered	{W 369}		

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
	34G277	A. BUILDING ______ B. WING ______	R 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASON STREET	306 N MASON STREET APEX, NC 27502

(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 369}	Continued From page 1	{W 369}		

grilled skinless chicken, prepared bite size pieces for dinner. Client #5 was observed to quickly filled his mouth with food. There were no observations of staff at the table, prompting client #5 to slow his eating pace. No problems were noted with ingestion.

A breakfast observation on 7/12/23 at 7:15 am in the home, revealed Staff D permit client #5 to remove 3 whole pancakes from a bowl. Client #5 hurriedly ate one pancake in 3 large bites. The HM prompted Staff D to get the bowl with the bite sized pancakes, and then client #5 was given an extra pre-cut pancake. Client #5 ate all of the pancakes without incident. Client #5 was observed with two large cups; one clear cup was filled to the rim with water and the fluid level could not be determined in the opaque gray cup.

Review on 7/11/23 of the occupational therapy evaluation from 4/14/23 revealed staff should fill cup halfway or offer two cups half-filled to decrease aspiration risks. Staff should pre-cut foods as needed in the kitchen due to client #5 eating at fast paced.

Interview on 7/12/23 with the HM revealed Staff D normally did not work the morning shift or assist with meal supervision and required some prompting.

Interview on 7/12/23 with the Program Director revealed client #5 likes to eat very fast and meal guidelines need to be followed.

During observations on 9/11/23 from 3:40 pm to 3:58 pm revealed Staff D administer medications to client #4. Client #4 received 2 different eye drops for his left eye: Brimonidine Sol 0.2% and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G277	A. BUILDING ______ B. WING ______	R 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASON STREET	306 N MASON STREET APEX, NC 27502

(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 369}	Continued From page 2 Dorzolamide HCL-Timolol Maleate 2.23%/0.08% and the following pills, Baclofen, Levetiracetam. Kristalose powder was added to water and drunk by client #4. Staff D was not observed to apply an eye drop to client #4's right eye. Review on 9/11/23 of client #4's Physician's Orders signed on 4/17/23 revealed a prescription for Polyvinyl Alcohol Solution 1.4% OP for the right eye. Interview on 9/11/23 with Staff D revealed upon further review of the electronic medication administration record (EMAR) he had placed a check on given Polyvinyl Alcohol Solution but had forgotten to scan that it was given. Staff D checked the bag that the eye drops were contained in and verified there was a bottle of the Polyvinyl Alcohol Solution available. Interview on 9/11/23 with the Home Manager revealed that he advised Staff D to call the triage team for the medication error and he reminded him to always scan the medication first before checking that it was given on the EMAR.	{W 369}		