

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G347	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCFARLAND ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 214 MCFARLAND ROAD ENFIELD, NC 27823
---	--

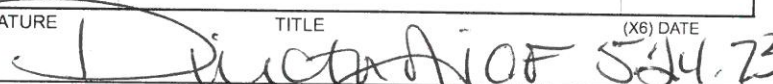
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 436	<p>SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)</p> <p>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 observations, record review and interviews, the facility failed to ensure 1 of 3 audit clients (#5) was taught to use and make informed choices regarding the use of his eyeglasses. The finding is:</p> <p>During observations throughout the survey on 5/15/23 - 5/16/23, client #5 did not wear eyeglasses. The client was not prompted or encouraged to wear eyeglasses.</p> <p>Review on 5/15/23 of client #5's eye exam, dated 11/20/20, revealed a prescription for full-time glasses due to a diagnosis of Presbyopia and age related cataracts.</p> <p>Review on 5/15/23 of client #5's individual program plan (IPP), dated 7/26/22, revealed a nursing service for glasses. The IPP further listed glasses as required adaptive equipment.</p> <p>Interview on 5/16/23 with the qualified intellectual disabilities professional (QIDP) revealed client #5's glasses were only used for reading as he often chooses to not wear his glasses.</p> <p>Interview on 5/16/23 with the facility nurse revealed client #5's glasses were prescribed for full-time use.</p>	W 436	<p>The facility will ensure that all consumers are informed and taught the proper use of adaptive equipment. The facility will ensure that each consumer receives needed interventions and services to support the achievement of proper eye wear, as identified in their IPP. Staff will be inserviced to review the use of all adaptive equipment and the proper use. The plan of correction will be monitored by the House Manager and QP through scheduled monthly inspections a minimum of 3x's per month.</p>	07/15/2023
-------	---	-------	---	------------

RECEIVED

MAY 30 2023

DHSR-MH Licensure Sect

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE 5/24/23
---	---	-----------------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G347	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MCFARLAND ROAD	STREET ADDRESS, CITY, STATE, ZIP CODE 214 MCFARLAND ROAD ENFIELD, NC 27823
---	--

(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 436	Continued From page 1 Further interview on 5/16/23 with the QIDP revealed client #5 should be wearing glasses full-time and staff should prompt client #5 to wear his glasses.	W 436		
-------	---	-------	--	--