DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB NO.</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í	IPLE CONSTRUCTION	· · ·	E SURVEY IPLETED
		34G175	B. WING _		06/	25/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME			3801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 039	CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §482 §485.542(d)(2), §48 §485.920(d)(2), §48		E 03	39		
	at §485.542, OPO, §485.727, CMHCs §491.12, and ESRE (2) Testing. The [fac	"Organizations" under at §485.920, RHCs/FQHCs at ) Facilities at §494.62]: cility] must conduct exercises				
LABORATOR	<ul> <li>must do all of the formulation of the formulation of the formulation of the employed of the formulation of the e</li></ul>	ull-scale exercise that is every 2 years; or unity-based exercise is not t a facility-based functional ars; or y] experiences an actual de emergency that requires bergency plan, the [facility] is ping in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: eale exercise that is or individual, facility-based or	NATURE	TITLE		(X6) DATE

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

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.

## PRINTED: 07/03/2024

		AND HUMAN SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G175	B. WING			06/2	25/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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
E 039	a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (iii) Analyze the [fac maintain documents exercises, and emer [facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based e (A) When a commu accessible, conduct functional exercise (B) If the hospice ex- man-made emergent the emergency plan engaging in its next community-based function onset of the emerged (ii) Conduct an add opposite the year the exercise under para is conducted, that n to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaster (C) A tabletop exer	udes a group discussion using y-relevant emergency of problem statements, , or prepared questions ge an emergency plan. Sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not t an individual facility based every 2 years; or xperiences a natural or ncy that requires activation of n, the hospital is exempt from crequired full scale exercise or individual onal exercise following the ency event. ditional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	EO	139			

If continuation sheet Page 2 of 23

		AND HUMAN SERVICES				FORM	: 07/03/2024 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G175	B. WING	i		06/	25/2024
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	AY 117 GROUP HOME				801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The h exercises to test the year. The hospice (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functi (B) If the hospice ex- man-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an ador may include, but is (A) A second full-se community-based or exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the hor maintain document exercises, and emerge	y-relevant emergency of problem statements, or prepared questions age an emergency plan. bices that provide inpatient nospice must conduct e emergency plan twice per must do the following: annual full-scale exercise that d; or unity-based exercise is not it an annual individual ional exercise; or xperiences a natural or ency that requires activation of n, the hospice is exempt from t required full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or rcise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to	E	039			

Facility ID: 922849

If continuation sheet Page 3 of 23

		AND HUMAN SERVICES					FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION G		(X3) DATE	E SURVEY PLETED
		34G175	B. WING	;			06/2	25/2024
NAME OF F	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP COD	E		
HIGHWA	Y 117 GROUP HOME				3801 US 117 NORTH GOLDSBORO, NC 27530			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD	) BE	(X5) COMPLETION DATE
E 039	§482.15(d), CAHs a (2) Testing. The [PF conduct exercises t twice per year. The do the following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the [PRTF, Ho actual natural or mar requires activation of [facility] is exempt for required full-scale of facility-based function onset of the emerge (ii) Conduct an and that may includ following: (A) A second full-sc community-based of functional exercise; (B) A mock (C) A tabletop e led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the maintain documents	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must a annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based f or disaster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared I to challenge an emergency e [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	E	039	9			

If continuation sheet Page 4 of 23

		AND HUMAN SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G175	B. WING	i		06/	25/2024
NAME OF P	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				3801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the PACE exp man-made emergen the emergency plan engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the y exercise under para is conducted that m the following: (A) A second full-so community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator and inclu- using a narrated, cli scenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain documenta exercises, and eme PACE's emergency *[For LTC Facilities	CE organization must conduct e emergency plan at least E organization must do the annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or periences an actual natural or ncy that requires activation of n, the PACE is exempt from required full-scale community facility-based functional he onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited to cale exercise that is or individual, a facility based or er drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, , or prepared questions ige an emergency plan. .CE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed. at §483.73(d):]	EC	039			
		] must conduct exercises to					

If continuation sheet Page 5 of 23

TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· /		(X3) DA	). 0938-039 TE SURVEY MPLETED		
				NG				
		34G175	B. WING _		06	/25/2024		
	PROVIDER OR SUPPLIER Y 117 GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3801 US 117 NORTH GOLDSBORO, NC 27530				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE		
E 039	test the emergency including unannour emergency procedu ICF/IID] must do th (i) Participate in an is community-based (A) When a commu accessible, conduc facility-based functi (B) If the [LTC facility actual natural or marequires activation LTC facility is exem- required a full-scale individual, facility-ba- following the onset (ii) Conduct an add may include, but is (A) A second full-scale individual, facility-ba- following the onset (ii) Conduct an add may include, but is (A) A second full-scale functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically- and a set of problem messages, or prepa- challenge an emerg (iii) Analyze the [LT and maintain docur exercises, and emergent [LTC facility] facility *[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergent The ICF/IID must d	<ul> <li>plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: a annual full-scale exercise that d; or unity-based exercise is not t an annual individual, fonal exercise.</li> <li>ity] facility experiences an an-made emergency that of the emergency plan, the opt from engaging its next e community-based or ased functional exercise that not limited to the following: cale exercise that is or an individual, facility based ; or er drill; or rcise or workshop that is led by s a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. TC facility] facility's response to mentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed.</li> <li>exa.475(d)]: F/IID must conduct exercises for year.</li> </ul>	Ε 03	39				

If continuation sheet Page 6 of 23

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/03/2024 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		34G175	B. WING			06/2	25/2024			
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
HIGHWA	Y 117 GROUP HOME		3801 US 117 NORTH GOLDSBORO, NC 27530							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
E 039	is community-based (A) When a commu accessible, conduct facility-based function (B) If the ICF/IID ex- man-made emerged the emergency plane engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and incl using a narrated, cli scenario, and a set directed messages, designed to challen (iii) Analyze the ICF maintain documenta exercises, and eme ICF/IID's emergenc '*[For HHAs at §484 (d)(2) Testing. The to test the emergen least annually. The (i) Participate in a fu community-based; of (A) When a cor accessible, conduct	d; or inity-based exercise is not t an annual individual, onal exercise; or. periences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from required full-scale or individual, facility-based following the onset of the itional annual exercise that not limited to the following: ale exercise that is or an individual, facility-based or drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, , or prepared questions ge an emergency plan. //IID's response to and ation of all drills, tabletop ergency events, and revise the ey plan, as needed. 02] HHA must conduct exercises cy plan at HHA must do the following: ull-scale exercise that is	EC	039						

		AND HUMAN SERVICES				FORM	07/03/2024 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G175	B. WING			06/25/2024		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HIGHWA	Y 117 GROUP HOME				801 US 117 NORTH GOLDSBORO, NC 27530			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 039	<ul> <li>(B) If the HHA</li> <li>or man-made emer</li> <li>of the emergency p</li> <li>engaging in its next</li> <li>community-based of</li> <li>functional exercise</li> <li>emergency event.</li> <li>(ii) Conduct an addi</li> <li>opposite the year the</li> <li>exercise under para</li> <li>is conducted, that</li> <li>limited to the following</li> <li>(A) A second functional exercise;</li> <li>(B) A mock disa</li> <li>(C) A tabletop e</li> <li>led by a facilitator at</li> <li>discussion, using a</li> <li>emergency events, directed</li> <li>questions designed</li> <li>plan.</li> <li>(iii) Analyze the HHL</li> <li>documentation of a</li> <li>emergency plan, as</li> <li>*[For OPOs at §486</li> <li>(d)(2) Testing. The to</li> <li>to test the emergen</li> <li>following:</li> <li>(i) Conduct a paper</li> <li>workshop at least a</li> <li>led by a facilitator a</li> <li>discussion, using a</li> </ul>	experiences an actual natural rgency that requires activation lan, the HHA is exempt from threquired full-scale or individual, facility based following the onset of the itional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ing: ill-scale exercise that is or an individual, facility-based for aster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared I to challenge an emergency A's response to and maintain II drills, tabletop exercises, and and revise the HHA's is needed.	EO	139				

Facility ID: 922849

If continuation sheet Page 8 of 23

		AND HUMAN SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				3801 US 117 NORTH GOLDSBORO, NC 27530		
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E 039	questions designed plan. If the OPO ex man-made emerge the emergency plan engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[ RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followin (i) Conduct a paper least annually. A tat discussion led by a clinically-relevant en of problem stateme prepared questions emergency plan. (ii) Analyze the RNH maintain document and emergency even emergency plan, as This STANDARD is Based on document facility failed to ensu- community/facility-to tabletop exercise to Preparedness (EP) finding is: Review on 6/24/24 updated on 2/28/24	I to challenge an emergency periences an actual natural or ncy that requires activation of n, the OPO is exempt from t required testing exercise of the emergency event. O's response to and maintain II tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: -based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's s needed. s not met as evidenced by: nt review and interviews, the	EC	039			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G175 B. WING 06/25/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3801 US 117 NORTH **HIGHWAY 117 GROUP HOME** GOLDSBORO, NC 27530 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 039 Continued From page 9 E 039 Interview on 6/25/24 with the Facility Services Suppotr Director confirmed no full scale community/facility-based exercise, mock drill or tabletop exercise had been conducted. W 122 CLIENT PROTECTIONS W 122 CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to implement written policies and procedures that prohibited neglect (W149). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients, specifically client #4. W 149 STAFF TREATMENT OF CLIENTS W 149 CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, record/document reviews, and interviews, the facility neglected to ensure client #4's food consistency was reassessed, specific meal time guidelines were developed/implemented and staff were sufficiently trained regarding his dining needs. This affected 1 of 3 audit clients (#4). The finding is: During lunch observations in the home on 6/24/24 at 11:54am, Staff B served client #4 tomato soup, a turkey lunch meat sandwich, pears (sliced in half), with thin liquids of Kool-aid and water. The staff used their gloved hands to break up the

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 10 of 23

PRINTED: 07/03/2024

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	): 07/03/2024 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ´		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		34G175	B. WING			06	/25/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 149	sandwich pieces we resembling the size His pears were ther by staff using the ed were noted to be at sticks. At the meal, Provale cup with an infrequently to drink towards the end of from the cup without the meal, client #4 staff responded to H asking the client if H or interventions wer During dinner obset 6/24/24 at 4:50pm, thick slices of meat potatoes with added slice of lemon pie, w water. A Provale cup provided at the meat food items without H pieces. Towards the the meat loaf into p quarter to a silver d remained unaltered Provale cup with the drinks. Towards the removed the lid and drink. Throughout th frequently. The two coughing by occasi No other prompts of	es. Once finished, the ere of various sizes of a quarter or silver dollar. In broken into smaller pieces dge of a serving spoon and bout the size of mini carrot client #4 was provided a a adaptive lid which he utilize a from. The client waited until the meal and drank his liquid at the lid applied. Throughout coughed frequently. The two his coughing by occasionally ne was ok. No other prompts re provided. rvations in the home on Staff C served client #4 two loaf, dry/thick mashed d cheese, cabbage, whole with thin liquids of tea and p with an adaptive lid was al. Client #4 began consuming his meat being cut into smaller e end of the meal, a staff cut ieces resembling the size of a ollar. Other food items . The client initially used the e lid attached to consume his he meal, the client coughed staff responded to his onally asking him if he was ok. r interventions were provided.	W -	149			
	6/25/24 at 7:20am,	Staff E assisted client #4 to hole sausage patties, two					

If continuation sheet Page 11 of 23

		AND HUMAN SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<b>‹</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	slices of toast (with with thin liquids of ju the food items, Staf pieces resembling to meal, client #4 put I together making a s The client also cons Provale cup was uti meal; however, the while eating but did was finished eating #4 consistently cour approached the clien and patted him on f asked if he was ok. Observation on 6/24 (written by the dietit the dining room of to ingests a "Regular of 2nd after eating all eat all on his place Double snack. Use liquids." The list did regarding client #4's Interview on 6/25/24 Medication Technic "coughs a lot" at ev when "he's just sittin staff indicated clien dining room which of double portions of f specify that his food interview indicated they have told nursi	added jelly), a whole banana, uice and water. After serving ff E cut the sausage into the size of a quarter. At the his two slices of toast with jelly sandwich and consumed it. sumed his banana uncut. A ilized while drinking at the client drank very infrequently drink all of his juice once he . Throughout the meal, client ghed loudly. Staff E ent on two separate occasions his back while another staff 4/24 of each client's diet tian, dated 4/10/24) posted in the home noted client #4 diet, double portions, serve on his place. If he does not seconds may not be served. Provale cup for drinking all not indicate any information	W 1	49			

If continuation sheet Page 12 of 23

		AND HUMAN SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED
		34G175	B. WING	i		06/:	25/2024
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				801 US 117 NORTH GOLDSBORO, NC 27530		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	Interview on 6/25/24 client #4's food is si up because he has Additional interview cough much but it of staff noted his Prov so he won't choke. Review on 6/25/24 orders dated 4/14/1 double portions to b meal ordered in a re snacks, cut food int pieces. Use Provale monitor while eating clients' current phys indicated he receive portions and a Prov drinking. The current information regardin Review on 6/25/24 Pathology swallow a diagnosis of orop study noted client # thick puree, honey to intermittent penetra across trials with th These volitional ress in clearing aspiratio improving, patient is resumption of po (b Review on 6/25/24 the interdisciplinary year ago to discuss The Core Meeting s	024 with Staff D revealed upposed to be cut or chopped no teeth and cannot chew it. vindicated client #4 doesn't depends on what he eats. The vale cup slows down the liquid of client #4's old physician's 15 revealed the following: "Diet be served on plate except estaurant from menu. Double to approximately ¼ to ½ e cup for drinking fluids, g." Additional review of the sician's orders 6/1 - 6/30/24 es a regular diet with double vale cup should be used for nt order did not specify any ng his food consistency. of client #4's Speech and study dated 08/06/20 revealed haryngeal dysphagia. The t4 was trialed with "thin, puree, thick liquids, via spoon with ation and aspiration noted troat clear or cough responses. sponses were not fully effective on. Although swallow is s not appropriate for	W	149	· · · · ·		

If continuation sheet Page 13 of 23

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G175	B. WING			06/	25/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HIGHWA	Y 117 GROUP HOME				3801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 149	aspirates and a fee At the time, the gua with emphasis on q coughing episodes, discussion on what him with as much c Provale cup when c delivery of liquids. [I #4's] physician, has does not recomment this time but will or request. Staff monit re-inserviced on the is fully aware of clie together to ensure the Review on 6/25/24 summary dated 7/2 following: "At baseli of aspiration; speech he underwent repeat after further discuss his guardian, we we regular consistency Provale cup (allows wish was not to mo PEG tube placement I agree with. I believ ongoing discussion his PCP." Review of client #4' addendum dated 08 "Diet Regular doubl after he eats all foo use Provale cup for review of the Nutriti	ge 13 ed show that client #4 ding tube was recommended. rdian denied the feeding tube uality of life. Due to his we wanted to reopen the team is doing to provide are as possible. He uses a drinking liquids to prevent over Physician's name], [Client ordered a chest x-ray. He ad another swallow study at der one upon guardian tor him as he eats and will be e signs of aspiration. The team nt #4's cough and will work that he remains healthy." of a local hospital's discharge 9/20 - 8/11/20 revealed the ne patient has a known history th therapy was following along, at modified barium study and sion with the facility along with ere informed he has a diet of with thin liquids and use of 5-10 cc per sip). Guardians ve forward with any kind of nt for long-term feeding, which <i>ve</i> this will need to be an with her/the organization and s/03/23 revealed the following: e portions to be served only d on first plate, double snacks, drinking all liquids." Additional onal evaluation also noted: cup to slow liquid volume and	W	149			

If continuation sheet Page 14 of 23

DEPARTMENT OF HEALTH AND HUMAN SERV CENTERS FOR MEDICARE & MEDICAID SERV			FORM	07/03/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA (X2) MU	JLTIPLE CONSTRUCTION DING	(X3) DATE	E SURVEY PLETED
34G175	B. WING	G	06/2	25/2024
NAME OF PROVIDER OR SUPPLIER	I	STREET ADDRESS, CITY, STATE, ZIP COL		
HIGHWAY 117 GROUP HOME		3801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BYTAGREGULATORY OR LSC IDENTIFYING INFORMA	FULL PREF	FIX (EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
<ul> <li>W 149 Continued From page 14 reduce risk of aspiration. Goals: continu diet. Monitor mealtime closely for signs symptoms of aspiration. Guidelines in pl monitoring." Additional review of the add did not indicate the client's current food consistency.</li> <li>During Staff D's interview on 6/24/24, the revealed they document the frequency or #4's coughing, choking or vomiting durin on food intake sheets. Additional intervie indicated the sheets are pulled monthly nurse.</li> <li>Review of client #4's food intake chart re daily documentation of food consumed b client and any observed coughing, chok vomiting. The documentation noted coup a daily basis during various meals while consuming a variety of foods over sever months.</li> <li>Interview on 6/25/24 with the Residentia Supervisor (RSS) revealed that she retri food intake charts for client #4 monthly. indicated she reviews the data, but does share the information with anyone, unles ask for it. She stated she thought it was to go to nursing for them to review but s told to keep it. During the interview, whe what she does when staff voice concern client #4's coughing while eating, she re she refers staff to the nurse. When aske know if client #4's food is to be chopped responded, staff told her that his food is chopped up, but she thought only his me chopped. During the interview, the RSS indicated if client #4 takes the top off his</li> </ul>	e current and ace for dendum e staff of client ng meals ew by the evealed oy the ing and ghing on ral I Support ieves the The RSS is not ss they supposed he was in asked is about vealed ed did she up, she to be eats were is also			

If continuation sheet Page 15 of 23

		AND HUMAN SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		34G175	B. WING			06/:	25/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				801 US 117 NORTH GOLDSBORO, NC 27530		
					-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	Continued From pa	ge 15	W	149			
	revealed client #4's but staff cut larger p make it easier for h indicated he has no not like them and d interview with the n history of aspiration guardian refused a interview, when ask instructions are writ physician's orders, food consistency in in his IPP or on a cu stated, "Staff just ge Additionally, when a know to cut client # staff verbally pass t When asked if she document food inta vomiting during me anything about a fo may know. Interview on 6/25/2¢ confirmed client #4 has Provale cups w lids attached. When taken to ensure his indicated someone client #4 while eatin asked if food consis with the interdiscipli food consistency ha has not received a about client #4's co she was aware of a	4 with the facility nurse food consistency is regular, pieces into bite size pieces to im to swallow. She also teeth, has dentures but does oes not wear them. Additional urse confirmed client #4 has a b, and she was told the feeding tube. During the teed if food consistency then in his IPP or on his current she indicated there are no structions for client #4 written urrent physician's order. She o on word of mouth." asked how new staff would 4's food, she indicated the old he information to new staff. knew about the form used to ke and coughing, choking, or als, she indicated not knowing rm, but stated her supervisor has a history of aspirating and thich should be used with the n asked what steps she has safety while eating, she must be at the table with og to ensure his safety. When stency has been discussed inary team, she revealed that as not been discussed and she call or any written notification ughing at meals. When ask if a physician's order for client #4 h recommended his food be					

If continuation sheet Page 16 of 23

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       34G175       B. WING       06/25/2024         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 3801 US 117 NORTH GOLDSBORO, NC 27530       3801 US 117 NORTH GOLDSBORO, NC 27530       06/25/2024			AND HUMAN SERVICES				FORM	07/03/2024 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLER     If UNIT NORTH       HIGHWAY 117 GROUP HOME     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF PROVIDER OR SUPPLER     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF PROVIDER OF DEFICIENCIES     BOD STATE, ZIP CODE       IMAGE OF PROVIDER OF DEFICIENCIES     DEPOTOENS FOLLO FOR CORRECTIVE AND SERVICE OF OTHER ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF PROVIDER OF DEFICIENCIES     DEPOTOENS FOLLO SCORECTION HOULD BE CORRECTIVE AND SERVICE OF OTHER ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF PROVIDERS OF ADDRESS, CITY, STATE, ZIP CODE     CONSTRET       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, CITY, STATE, ZIP CODE       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, STATE, ZIP CODE       IMAGE OF TAX STATE, ZIP CODE     STREET ADDRESS, STATE, ZIP CODE       IMAGE OF TATE, STATE, ZIP CODE	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY
HIGHWAY 117 GROUP HOME     381 US 117 NORTH GOLDSBORO, NC 27530       W1 ID PRETX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     IPRETX TAG     PROVIDER'S FLAN OF CORRECTION (EACH OPERCENCE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)     IPRETX TAG       W 149     Continued From page 16 cut in ½ and ½ pieces, she indicated having no knowledge of the order and why the cut food consistency was not in his most current physician's order. During the interview, when asked what guidelines are in place for monitoring and safety, she revealed that the guideline for monitoring is to complete the food intake sheets and for staff be present at the table with client #4. However, the nurse supervisor also indicated that she does not review or monitor the food intake sheets for client #4.     W 149       Interview on 6/25/24 with the Qualified interdisciplinary Disabilities Professional (QIDP) revealed client #4 is not a 1800 calorie, regular diet with double portions and double portion snacks. Additionally, when asked if ficient #4 uses the Provale cup, when asked if ficient #4 uses the Provale cup, when asked if client #4 uses the Provale cup, she responded, "He uses his Provale cup, she responded, THe uses his Provale cup, she responded, THe uses his Provale cup, she responded that she heard about be redirected by staff, I think." The QIDP indicated she would have to review the previous physician's order for client #4 dated 4/15/15 which recommended his food intake at the meal, she responded that is he heard about the data sheep to the data being gathered and kept regarding client #4's food intake at the meal, she responded that is he heard about be data sheep to the data being reviewed. Additionally, the QIDP stated she did			34G175	B. WING			06/:	25/2024
HIGHWAY 117 GROUP HOME     GOLDSBORO, NC 27530       (X4) JD PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDE BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)     ID PROVIDER'S PLAN OF CORRECTIVE AND SEPARATION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE     COME COMERCINE DEFICIENCY)       W 149     Continued From page 16 cut in ½ and ½ pieces, she indicated having no knowledge of the order and why the cut food consistency was not in his most current physician's order. During the interview, when asked what guidelines are in place for monitoring and safety, she revealed that the guideline for monitoring is to complete the food intake sheets and for staff be present at the table with client #4. However, the nurse supervisor also indicated that she does not review or monitor the food intake sheets for client #4.     Interview on 6/25/24 with the Qualified Interdisciplinary Disabilities Professional (QIDP) revealed client #4 fis food should be cut, she noted his most current physician's orders dated 6/1/24- 6/30/24 do not indicate his food should be cut. When asked if his food should be cut, into 0/2 and ½ pieces.     Hink, "The QIDP indicated she would have to review the previous physician's order for client #4 dated 4/15/15 which recommended his food should be cut. When asked if hour to conver the previous physician's order for client #4 dated 4/15/15 which recommended his food hou be cut into ½ and ½ pieces.       During further interview with the QIDP, when asked if she was aware of the data being gathered and kept regarding client #4 stood intake at the meal, she responded that she heard about the data sheet but the data is not being reviewee. Additionally, the QIDP stated she did	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
Pričerk TAG       (EACH OEFICIENCY NUST BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRĚTX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY)       COMĚLÉTE DEFICIENCY)         W 149       Continued From page 16 cut in ¼ and ¼ pieces, she indicated having no knowledge of the order and why the cut food consistency was not in his most current physician's order. During the interview, when asked what guidelines are in place for monitoring and safety, she revealed that the guideline for monitoring is to complete the food intake sheets and for staff be present at the table with client #4.       W 149         Interview on 6/25/24 with the Qualified Interdisciplinary Disabilities Professional (QIDP) revealed client #4 so na 1800 calcine, regular diet with double portions nack double portion snacks. Additionally, when asked if his food should be cut, she noted his most current physician's orders dated 6/1/24- 6/30/24 do not indicate his food should be cut. When asked if client #4 uses the Provale cup, she responded. "He uses his Provale cup, she responded his food to be cut into ½ and ½ pieces.       The QIDP indicated she would have to review the previous physician's order for client #4 food intake at the meal, she responded that she heard about the data sheet but the data being gathered and kept regarring client #4 food intake at the meal, she responded that she heard about the data sheet but the data being reviewed. Additionally, in QIDP stated she did	HIGHWA	Y 117 GROUP HOME						
cut in ¼ and ½ pieces, she indicated having no       k110         cut in ¼ and ½ pieces, she indicated having no       k110         consistency was not in his most current       physician's order. During the interview, when         asked what guidelines are in place for monitoring       and safety, she revealed that the guideline for         monitoring is to complete the food intake sheets       and for staff be present at the table with client #4.         However, the nurse supervisor also indicated that       she does not review or monitor the food intake         sheets for client #4.       Interview on 6/25/24 with the Qualified         Interview on 6/25/24 with the Qualified       Interview on 6/25/24 with the Qualified         Interview on 6/25/24 with the Qualified       Interview on 6/25/24 with the Qualified         Interview on 6/25/24 with the Qualified       Interview on 6/25/24 with the Qualified         Interdisciplinary Disabilities Professional (QIDP)       revealed client #4's on a 1800 calorie, regular diet         with double portions and double portion snacks.       Additionally, when asked if client #4 uses the         Provale cut. When asked if client #4 uses the       Provale cup, she responded, "He uses his         Provale cup, she responded, "He uses his       Provale cup when drinking, and if he takes the lid         off, he should have to review the       previous physician's order for client #4 food         UDP indicated she would have to	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
cutting the client's food. The QIDP indicated staff are to observe client #4 closely when eating to keep him safe during meals because of his risk of aspirating.	W 149	cut in 1⁄4 and 1⁄2 piece knowledge of the or consistency was no physician's order. If asked what guidelin and safety, she reve monitoring is to com and for staff be pres However, the nurse she does not review sheets for client #4. Interview on 6/25/24 Interview on 6/25/24 Interdisciplinary Dis revealed client #4's with double portions Additionally, when a she noted his most dated 6/1/24- 6/30/2 should be cut. Whe Provale cup, she re Provale cup, she re QIDP indicated she previous physician's 4/15/15 which recor into 1⁄2 and 1⁄4 pieces During further interva asked if she was av gathered and kept n intake at the meal, about the data sheet reviewed. Additionan not know staff have cutting the client's f are to observe client keep him safe durint	<ul> <li>bes, she indicated having no roler and why the cut food of in his most current.</li> <li>During the interview, when hes are in place for monitoring ealed that the guideline for inplete the food intake sheets sent at the table with client #4.</li> <li>e supervisor also indicated that wor monitor the food intake sheets.</li> <li>4 with the Qualified sabilities Professional (QIDP) on a 1800 calorie, regular diet is and double portion snacks.</li> <li>asked if his food should be cut, current physician's orders 24 do not indicate his food en asked if client #4 uses the esponded, "He uses his drinking, and if he takes the lid edirected by staff, I think." The would have to review the sorder for client #4 dated mmended his food to be cut s.</li> <li>view with the QIDP, when ware of the data being regarding client #4's food she responded that she heard et but the data is not being ally, the QIDP stated she did a been trained regarding to the data staff at #4 closely when eating to the taken the did at #4 closely when eating to the data staff at #4 closely when eating to the data staff at #4 closely when eating to the data data the data staff at #4 closely when eating to the data data data the data staff at #4 closely when eating to the data data data the data the data the data the data the data the data staff at #4 closely when eating to the data data data the data</li></ul>		149			

If continuation sheet Page 17 of 23

		AND HUMAN SERVICES				FORM	07/03/2024 APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPLE	OI E CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` ´			COMPLETED	
		34G175	B. WING			06/2	25/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWAY 117 GROUP HOME					301 US 117 NORTH OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	Continued From pa	ige 17	W 1	49			
W 159	Review on 6/25/24 Rights/Affair's polic neglect is defined a represents acts or of commission, the fail services necessary mental anguish, or as neglect, an act ( constitute actual da emotional, or social consumer. Further follows: A. Inadequa consumer. B. Failur care. C. Failure to a or participates in ha consumer has prev unwholesome or de Based on client #4's risk of aspiration wh coughing at meals, client's food consist specific mealtime g developed and staff ensure the client's s failure constituted m QIDP CFR(s): 483.430(a) Each client's active integrated, coordina qualified intellectua This STANDARD is Based on record re Qualified Intellectua (QIDP) failed to ensure	of the facility's Consumer y (last review 01/01/14) noted as "Negligence generally omission rather than ilure to provide goods and to avoid physical harm, mental illness. To be classified or omission of an act), must amage to the physical, I development of the definition of neglect is as ate supervision or control of re to assure essential medical assure the consumer attends abilitation program to which the riously agreed. D. Exposure to emoralizing circumstances." s diagnosis of dysphasia, his hile eating and his observed the facility failed to ensure the tency was reassessed, juidelines/instructions were f were sufficiently trained to safety during dining. This neglect.	W 1				

Facility ID: 922849

If continuation sheet Page 18 of 23

		AND HUMAN SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE	E SURVEY IPLETED
		34G175	B. WING			06/:	25/2024
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				801 US 117 NORTH OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 159	Continued From pa	ige 18	W 1	59			
	This affected 2 of 3 findings are:	audit clients (#3 and #4). The					
		/24 of client #3's IPP dated the following objectives:					
	spends money, he	etting, when [Client #3] places his receipts from ck box for 6 consecutive secutive months."					
		etting, when instructed, [Client th for 6 consecutive sessions					
	in his training book the objectives had b Although the client objectives for almost progress notes for t	f client #3's written programs located in the home revealed been implemented on 7/7/20. had continued to train on the st 4 years, further review of the last 3 months indicated the training" and his projected ad been extended.					
	Specialist (HS) con were current and ha time. The HS indica	4 with the Habilitation firmed client #3's objectives ave been in place for a long ated the team will be updating es at his next planning					

If continuation sheet Page 19 of 23

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		34G175	B. WING _			06/2	25/2024
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				01 US 117 NORTH OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 159	Continued From pa meeting.	ge 19	W 15	59			
		4 with the QIDP also s objectives were current and anning meetings.					
		24 of client #4's IPP dated e following objectives:					
	#4] will correctly but consecutive data set	etting when requested, [Client tton up the button board for 9 essions per month for 6 s." (Implemented on 2/7/20)					
	#4] will brush all sur electric toothbrush	etting when requested, [Client faces of his teeth using an for 10 data sessions per s." (Implemented on 7/10/20)					
	repeat the name of consecutive data se	etting, [Client #4] will verbally a specific medications for 8 essions within one month mplemented on 2/23/22)					
	showed that client #	of the HS progress notes #4 continues to train on the er two to four years.					
W 288	client #4 continues		W 28	38			
	Techniques to man	age inappropriate client er be used as a substitute for					

If continuation sheet Page 20 of 23

		AND HUMAN SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		34G175	B. WING			06/:	25/2024
NAME OF	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				801 US 117 NORTH OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 288 W 436	an active treatment This STANDARD is Based on observat interviews, the facili to manage client #3 included in a forma The finding is: During morning obs 6/25/24, Staff E lock the medication roor Interview on 6/25/24 television remote is medication room be client in the home w what to watch on te Review on 6/25/24 Plan (BSP) dated 6 address noncomplis plan did not include television remote to behaviors. Interview on 6/25/24 Disabilities Profess remote should not the SPACE AND EQUII CFR(s): 483.470(g) The facility must fur and teach clients to choices about the u hearing and other of and other devices is interdisciplinary tea	program. s not met as evidenced by: tions, record review and ity failed to ensure a technique 3's inappropriate behavior was I active treatment program. servations in the home on ked the television remote in m. 4 with Staff E revealed the often locked in the ecause client #3 and another vill have arguments over it and levision. of client #3's Behavior Support /11/24 revealed an objective to ance. Additional review of the a technique of removing the b address his inappropriate 4 with the Qualified Intellectual ional (QIDP) confirmed the be kept locked. PMENT (2) mish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces,	W 2				

Facility ID: 922849

If continuation sheet Page 21 of 23

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G175	B. WING			06/2	25/2024
NAME OF PROVIDER OR SI	JPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWAY 117 GROUP	HOME				801 US 117 NORTH GOLDSBORO, NC 27530		
PREFIX (EACH DE	FICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
<ul> <li>interviews, t were furnish audit clients</li> <li>During obse 6/24 - 6/25/2 Client #5 wa wear eye gla Interview on 6 Program Pla has eye glas vision exam "Glasses ful Interview on Disabilities ful was not suru FOOD AND CFR(s): 483</li> <li>Each client well-balance specially-present This STANE Based on o reviews, the clients (#4) diets as indi</li> </ul>	bservat he facil ied as ii (#5). T rvations 24, clier is not p asses. 6/25/2 wear ey a. 6/24/24 an (IPP) sees. Ac ination I time". 6/25/2 Profess e where NUTRI 6.480(a) must re ed diet i escribed bservat facility received cated.	<ul> <li>ions, record review and ity failed to ensure eye glasses indicated. This affected 1 of 3 he finding is:</li> <li>is throughout the survey on at #5 did not wear eye glasses.</li> <li>is throughout the survey on at #5 did not wear eye glasses.</li> <li>is throughout the survey on at #5 did not wear eye glasses.</li> <li>is throughout the survey on at #5 did not wear eye glasses.</li> <li>is throughout the survey on at #5 did not wear eye glasses.</li> <li>is throughout the survey on at #5 did not wear eye glasses.</li> <li>is throughout the survey of a with Staff E revealed the ditional review of the client's report dated 11/16/23 noted,</li> <li>is the the Qualified Intellectual ional (QIDP) indicated she e client #5's eye glasses were.</li> <li>is the transmission of the survey of a nourishing, including modified and</li> </ul>	W 4				

Facility ID: 922849

If continuation sheet Page 22 of 23

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/03/2024 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G175	B. WING			06/2	25/2024
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HIGHWA	AY 117 GROUP HOME				801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 460	5:00pm, client #4 w meat loaf, cabbage During observation client #4 was serve turkey/Swiss sandw pears. During observations 7:11am, client #4 w oatmeal, turkey sau Review of client #4' (IPP) dated 10/5/23 double portions. Review on 6/24/24 4/10/24 posted in th Client #4 receives a Interview on 6/25/24 client #4 gets double dinner, but in the m double portions.	<ul> <li>vas served a single portion of e and potatoes onto his plate.</li> <li>of Lunch on 6/24 at 11:59 am, ed a single portion of vich, with tomato soup and</li> <li>s of breakfast on 6/25/24 at vas served a single portion of usage and toast.</li> <li>'s Individual Program Plan B revealed a regular diet,</li> <li>of client #4's diet plan dated he dining area revealed that a regular diet, double portions.</li> <li>4 with Staff D revealed that le portions with mostly lunch or norning client #4 does not get</li> <li>4 with the facility Nurse usified Intellectual Disabilities P) confirmed client #4's diet is</li> </ul>	W 4	460			

Facility ID: 922849

If continuation sheet Page 23 of 23