

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

PRINTED: 07/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER MASON STREET			STREET ADDRESS, CITY, STATE, ZIP CODE 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 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, document review and interviews the interdisciplinary team failed to ensure objective training to meet identified needs relative to the wearing of eyeglasses were implemented for 1 of 3 audit clients (#2). The finding is:</p> <p>During morning observations in the home on 7/23/24 from 5:40am - 7:56am, client #2 was not prompted to wear his eyeglasses. Further observations revealed client #2 was observed watching the television and putting together a puzzle.</p> <p>Review on 7/23/24 of client #2's visual examination dated 7/19/24 indicated he is to wear his eyeglasses full time.</p> <p>During an interview on 7/23/24, the Home Manager (HM) stated client #2 has not had a objective on the wearing of his eyeglasses.</p> <p>During an interview on 7/23/24, the Program Manager (PM) revealed client #2 has not had a training objective for the wearing of his eyeglasses.</p>	W 436			

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.