STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G297	A. BUILDING ______ B. WING ______	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE PLACE	**704 CAROLINA AVENUE AHOSKIE, NC 27910**

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that privacy was maintained during medication administration for 1 of 4 audit clients (#5). The finding is: During observations of the noon medication administration in the home on 8/19/24 at 12:15pm, Staff A administered medications to client #5 in the public den area with other clients present watching television. During morning medication administration at 8:30am, Staff C administered medications to client #5 in the public den area with other clients present watching television. Interview on 8/19/24 with Staff A revealed they take client #5's medication to him due to his unsteady gait. Interview on 8/20/24 with the Program Manager revealed they take medication to client #5 due to his gait, but he can participate in medication administration and it should be done in a private area. Interview on 8/20/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed clients should not receive medication administration in a public area and should be assured of privacy.	W 130		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe	W 240		

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
	34G297	A. BUILDING ______ B. WING ______	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE PLACE	704 CAROLINA AVENUE AHOSKIE, NC 27910

(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 240	Continued From page 1 relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #5's Individual Program Plan (IPP) included specific information to support his use of his ambulation. This affected 1 of 4 audit clients. The finding is: During afternoon observations in the home on 8/19/24, client #5 was observed to unsteadily stand in the den area and walk from the den area to the dining area with an unsteady gait and no staff near. Review on 8/20/24 of client #5's IPP, dated 4/22/24, revealed he has cerebral palsy, epilepsy, neuronal migration disorder, and joint hyperextension. He is ambulatory with good gross motor skills. No other ambulation needs are addressed in the IPP. Review on 8/20/24 of client #5's physical therapy evaluation,dated 7/20/24, revealed he has C curve scoliosis, callus formations on both feet, and feet overponuation. He can stand independently with staff standing by for assistance using arms and hands. He requires staff stand by to contact guard assistance for ambulation. In addition, he is a high falls risk and presents with postural faults and functional decline in mobility. Interview on 8/20/24 with the Program Manager revealed staff should be near client #5 when he is ambulating but he tends to try to be independent and get up quickly. Interview on 8/20/24 with the Qualified Intellectual	W 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G297	A. BUILDING ______ B. WING ______	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE PLACE	704 CAROLINA AVENUE AHOSKIE, NC 27910

(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 240

Continued From page 2

Disabilities Professional (QIDP) revealed the IPP was incorrect and should reflect client #5 as a falls risk with ambulation guidelines.

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 interviews, the facility failed to ensure 3 of 4 audit clients (#1, #4, and #5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of training during medication administration and leisure activies. The findings are:

A. Observation in the home on 8/19/24 from 1:30pm to 5:30pm revealed clients not attending the day program due to van repair without structured activities and minimal staff engagement. After lunch, from 1:30pm - 5:30pm, Clients #1, #4, and #5 sat in the den as either cartoons or music videos played on the television with little interaction from staff or scheduled activities. At 2:45pm, the Program Manager changed the television to music videos so that client #5 could sing. He remained in the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G297	A. BUILDING ______ B. WING ______	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE PLACE	**704 CAROLINA AVENUE AHOSKIE, NC 27910**

(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 rocking chair for most of the afternoon with the exception of briefly going to the dining table for a puzzle. Client #4 was given a puzzle on the table in front of him as he sat on the couch. Client #1 sat on the sofa, looking around the room. At 2:50pm, the Program Manager briefly sat next to client #4 to talk with him, and then began to unpack supplies and organize them in storage. At 4:00pm, client #5 moved to the table to work on a puzzle. The Program Manager attempted to talk with him, while also helping a staff to train for CPR at the dining table. Client #5 moved back to the rocking chair. At 4:30pm, Staff B arrived at work and went to sit with client #5 and play a game. Review of the Alternate Day Program Schedule, undated, revealed the following schedule: *1:00 pm - 2:00 pm Worksheets *2:00 pm - 3:00 pm Games *3:00 pm - 3:15 pm Snack *3:15 pm - 4:00 pm TV/Social Time Interview on 8/19/24 with the Program Manager revealed the home van had broken down in the previous week and would be returned to resume day program attendance on 8/20/24. The Program Manager had filled in to work overtime and acknowledged she had completed multiple duties while trying to work with the clients. Interview on 8/20/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed scheduled activities should occur if clients were not attending the day program. B. During afternoon medication administration in the home on 8/19/24 at 12:15pm, Staff A prepared client #5's medication and water in the	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G297	A. BUILDING ______ B. WING ______	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE PLACE	704 CAROLINA AVENUE AHOSKIE, NC 27910

(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 4 medication room, took the medication to the den, and spoon fed client #5 his medication. During morning medication administration on 8/20/24, Staff C prepared client #5's medication and water in the medication room, took the medication to the den, and spoon fed client #5 his medication. Review on 8/20/24 of client #5's Individual Program Plan (IPP), dated 4/22/24, revealed a need to locate his name on the medication administration report (MAR). Review on 8/20/24 of client #5's skills assessment, dated 2/6/24, revealed he pours beverages from a small pitcher into a glass, comes to medication area with prompting, and takes medication with water independently. Interview on 8/20/24 with the Program Manger revealed staff take client #5's medication to him in the mornings due to it being difficult for him to walk in the morning. The Program Manager acknowledged that he moves about the home at other times and can participate in medication administration. Interview on 8/20/24 with the QIDP revealed client #5 should go to the medication room to participate in medication administration.	W 249		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) 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.	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G297	A. BUILDING ______ B. WING ______	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE PLACE	**704 CAROLINA AVENUE AHOSKIE, NC 27910**

(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 5 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to furnish client #5 with elbow pads and wrist wraps. This affected 1 of 4 audit clients. The finding is: During observations in the home on 8/19 - 8/20/24, client #5 did not wear elbow pads or wrist bands. He was observed to have an unsteady gait as he moved around the den and dining area. In addition, he had visible, excessive drool hanging from his mouth. He was not offered wrist bands to address the drooling. Review on 8/20/24 of client #5's Individual Program Plan (IPP), dated 4/22/24, revealed has cerebral palsy, epilepsy, neuronal migration disorder, and joint hyperextension. His needs include the use of elbow pads to aid in preventing elbows from cuts and scrapes and wrist bands for help in containing the drool that comes from his mouth. Interview on 8/20/24 with the Program Manager and Qualified Intellectual Disabilities Professional (QIDP) revealed client #5 should have elbow pads and wrist bands. The facility has looked online to find new elbow pads and wrist bands, but none have been ordered.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted on every shift, each quarter. This potentially affected all clients (#1, #2, #3, #4, #5, and #6). The finding	W 440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G297	A. BUILDING ______ B. WING ______	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE PLACE	704 CAROLINA AVENUE AHOSKIE, NC 27910

(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 440	Continued From page 6 is: Review on 8/19/24 of fire drills conducted revealed the following details: There was no 1st or 2nd shift fire drill performed during the 4th quarter (May - July) of 2024. Interview on 8/20/24 with the Program Manager revealed fire drills should be completed each quarter and had not been completed as much this summer.	W 440		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on review of fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: Review on 8/19/24 of the facility's fire drills revealed three fire drills conducted between 7:30am and 8:00am on 1st shift and one drill without a documented time. During interview on 8/20/24, the Qualified Intellectual Disabilities Professional (QIDP) confirmed fire drills held during first shift were not held at varied times.	W 441		