ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/O	(X2) MULTIPL	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
			The state of the s		
W C	34G224	B. WING		401101000	
IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/19/2023	
COUNTRY LANE (X4) ID SUMMARY		5	534 COUNTRY LANE HOLLY SPRINGS, NC 27540		
	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	(Ve)	
TAG REGULATORY O	PR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETIC TE DATE	
PROTECTION OF CFR(s): 483.420(a) The facility must en Therefore, the facility individual clients to of the facility, and a including the right to due process. This STANDARD is Based on record refailed to assist 3 of exercise their individual comportunities for conductive opportunities of client #3 explained a company closed in 2 asked facility manages he could return to we revealed he wanted during family visits a personal items he was the was tirred of being without community without community without community without community without community opportunities of client #3's IPP reversional goals for mone opurchases.	asure the rights of all clients.  Ity must allow and encourage exercise their rights as clients as citizens of the United States, of file complaints, and the right is not met as evidenced by:  View and interview the facility is clients (#2, #3 and #5) to clients (#2, #3 and #5) to clients (#2, #3 and #5) to client rights to locate in the interview work. The finding is:  12/18/23 at 4:15pm in the interview wanted to at he could earn money, the had been employed at a refer the pandemic, the could earn money.  In the surveyor he wanted to at he could earn money. The finding is:  2021. Client #3 stated he had rement several times when ork. Further interview to earn money to spend and to purchase some anted. Client #3 stated that a fat the facility all day"	W 125	<ul> <li>W125 will be corrected by complete the following tasks:</li> <li>Residents will be offered the opportunity to work or attenday program/job readiness program.</li> <li>PM will consult with QIDP recompetitive work options.</li> <li>QIDP will gather pertinent paperwork for chosen competitive work options.</li> <li>QIDP and/or PM will submit paperwork to chosen day program/job readiness facilities.</li> <li>QIDP will work with the chooday program/job readiness facility to set a timeline for Country Lane residents to attend the day program.</li> <li>PM and/or QIDP will monitor monthly.</li> <li>AS and/or SS will monitor 2x month.</li> </ul>	end a e: by. sen tend	

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.

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

Event ID:LW2V11 Facility ID: 921705

If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  34G224		(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING			(X3) DATE SURVEY COMPLETED  12/19/2023		
	ROVIDER OR SUPPLIER	UTULET		534 C	ET ADDRESS, CITY, STATE, ZIP CODE COUNTRY LANE LY SPRINGS, NC 27540		
(X4) ID PREFIX	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFI	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
W 125			W	125			
	work and that he h intellectual disabili several times he w the community. Cl	age 1 about not returning to lad told the qualified ties professional (QIDP) ranted to return to working in lient #2 stated, "I would feel					
	Review on 12/18/2 6/18/23 also listed vocational setting work. Further revi working on formal	If if I was working."  23 of client #2's IPP dated  23 he was employed at a local  25 completing paid contractual  26 iew of the IPP revealed he is  26 goals to purchase items during  26 imunity and participating in a  27 once weekly.					
	facility, client #5 to a letter to a local t assist him in findin to work. He stated	on 12/18/23 at 4:30pm in the old the surveyor he had written elevision station asking them to any out why he could not return to go back to work."					
	3/11/23 revealed vocational setting work. Further rev he has formal gos community outing	23 of client #5's IPP dated he was employed at a local completing paid contractual iew of client #5's IPP revealed als to purchase items during s and participate in a at least once weekly.					
	manager (RM) re been very vocal a Further interview purchased the vo been asked to ge clients to attend t stated she had so management at t	8/23 with the residential vealed clients #2, #3 and #5 had about wanting to return to work. revealed another company had cational setting and that she had t guardian consents for the his vocational setting. The RM ubmitted these consents to he facility, once they were al guardians, however she had				J	

OMD .... ---- .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			TE SURVEY MPLETED
NAME OF F	PROVIDER OR SUPPLIER	34G224			12	2/19/2023
COUNTR	Y LANE		534	REET ADDRESS, CITY, STATE, ZIP CODE COUNTRY LANE LLY SPRINGS, NC 27540		
(X4) ID PREFIX TAG	(EACH DEFICIENC) REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 125	Continued From page arrangement had "fall heard anything furthe #3 and #5 continued it going back to work ar any visitors in the faci assist them.  Interview on 12/19/23 revealed facility mana approached by a comhad assumed owners setting that clients #1, attended. The PM was company and after go preliminary contract w 2023. The PM explain vocational contract fact the components of the meet the self care need Review on 12/19/23 or dated January 2023 be company for the vocat management company	pany in October 2021 who hip of a local vocational #2, #3 and #5 had a saked to meet with the ing over several details a las developed in January ed after reviewing the cility management realized a contract were not going to eds of their clients.  If the preliminary contract etween the management ional setting and the facility of the Program Manager	W 125			
	this vocational opportualso offered client #1's unhappy about the lack had reached out to bot setting and to facility minterview revealed their clients attending anoth however at the present	gement was unable to in February 2023 and that unity fell through. The PM guardian was very ex of vocational options and the potential vocational panagement. Additional re was discussion of the er vocational setting,			0	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CL	.IA /Y2\ MI II TIDI E	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	The same of the sa	CONSTRUCTION	COMP	LETED
		34G224	B. WING		12/	19/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRY	Y LANE_			34 COUNTRY LANE IOLLY SPRINGS, NC 27540		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 368			W 368	W368 will be corrected by comple	ting	02.16.2024
	DRUG ADMINISTRA	TION		the following:		
	CFR(s): 483.460(k)(1	)		<ul> <li>RN will ensure that Physicia</li> </ul>	an	
				orders are up to date, sign	ed,	
		administration must assure		and in the home. Physiciar	1	
		ninistered in compliance with		orders will detail current	i	
	the physician's order			medications to be given to	.	
		not met as evidenced by:		Country Lane residents.		
		ns, record reviews and		<ul> <li>RN, QIDP, AS, and/or SS wi</li> </ul>	lli lli	
	interviews, the facility	ministered in accordance		ensure all medications are	in the	
		rs. This affected 2 of 6 audit		home and ready for		
	clients (#1 and #3). T			consumption as prescribed	1.	
	ononto (ir randiro). I	no monig io.		<ul> <li>RN, QIDP, AS, and/or SS wi</li> </ul>	Iti	
	During observations	of medication administration		ensure autofill medications	are	
		m, staff D wrote down on a		checked in monthly. Any	-/-	
		ne was missing medications		inaccuracies or missing	/	
	for clients #1 and #3			medications will be correct upon check-in.	ed	
lue_ =	Review on 12/19/23	of client #1's physician		<ul> <li>RN, QIDP, AS and/or SS will</li> </ul>	Il train	
	orders revealed he is	prescribed Pantoprazole 40		staff on medication regime		
	mg. (1) tablet by mou ordered at 7:00am.	th twice daily which is		the medication check-in pr Staff will also be trained on	ocess.	
	Intention on 12/10/23	with staff D revealed client		to assist in obtaining missir	ng	
	#1 had been on thera			medication.		
	Commercial	and she did not realize that		<ul> <li>QIDP will monitor monthly</li> </ul>	·.	
		ole 40 mg. needed to be		<ul> <li>RN will monitor 2x a month</li> </ul>		
	The second secon	ing of 12/19/23. Staff D		<ul> <li>AS and/or SS will monitor 2</li> </ul>		
		the facility Nurse to start the		monthly.		
					/	
		client #3's physician orders				
	AND DESCRIPTION OF THE PARTY OF THE PROPERTY O	ibed Potassium Chloride 20				
	meq.; Take (1) tablet 7:00am.	once daily ordered at				
	Commonwealth to the second of	with staff D revealed client				
		re-ordered but the pharmacy Potassium Chloride 20 meq.				
		n. Staff D stated she had				
	23 01 12/10/20 at / all	Clair D viatod dilo liad				

Facility ID: 921705

IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/O	A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G224	B. WING _			0//0/0000	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE 1	2/19/2023	
COUNTR				534 COUNTRY LANE HOLLY SPRINGS, NC 27540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 368	Continued From page	e 4 contacted the facility	W 36	58			
	Nurse to make certain						
	available later in the of Interview on 12/19/23 (PM) revealed all med ordered by the physic	with the Program Manager					
					)		
					4		
			-				
			1				