PRINTED: 09/06/2024 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | | | |
|--|--|---|-------------------------------|-----|--|-------|----------------------------|--|
| | | 34G217 | B. WING | | | 09 | 09/04/2024 | |
| | PROVIDER OR SUPPLIER | | | 306 | REET ADDRESS, CITY, STATE, ZIP CODE CATES STREET DXBORO, NC 27573 | | | |
| (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 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), §41 §460.84(d)(2), §48 §483.475(d)(2), §4 §485.542(d)(2), §4 §485.920(d)(2), §4 *[For ASCs at §416 at §485.542, OPO, §485.727, CMHCs §491.12, and ESR (2) Testing. The [fato test the emerger must do all of the formunity-based (A) When a commaccessible, conduct exercise every 2 years, community-based functional exercise actual event. (ii) Conduct an add years, opposite the functional exercise this section is conduct in the formunity-based functional exercise this section is conduct in the formunity-based functional exercise this section is conduct in the formunity-based functional exercise (B) A mock disaster (C) A tabletop exercise (B) A mock disaster (C) A tabletop exercise (B) | 8.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.625(d)(2), §485.727(d)(2), 91.12(d)(2), §494.62(d)(2). 6.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]: acility] must conduct exercises acy plan annually. The [facility] ollowing: full-scale exercise that is every 2 years; or aunity-based exercise is not at a facility-based functional ears; or ty] experiences an actual de emergency that requires aregency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the ditional exercise at least every 2 a year the full-scale or a under paragraph (d)(2)(i) of ducted, that may include, but is ollowing: cale exercise that is or individual, facility-based ; or | EC | 039 | 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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | | |
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| | | 34G217 | B. WING | | 09 | /04/2024 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL 306 CATES STREET ROXBORO, NC 27573 | | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| E 039 | a facilitator and incia a narrated, clinically scenario, and a set directed messages designed to challer (iii) Analyze the [facility's] emergence exercises, and emergence [facility's] emergence *[For Hospices at 4 (2) Testing for hospatient's home. The exercises to test the annually. The hospice in a community based (A) When a community based (A) When a community based (B) If the hospice eman-made emergency planengaging in its next community-based facility-based functionset of the emerg (ii) Conduct an addopposite the year the exercise under part is conducted, that in to the following: (A) A second full-scommunity-based of exercise; or (B) A mock disaste (C) A tabletop exercise. | ludes a group discussion using y-relevant emergency of problem statements, or prepared questions age 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):] pices that provide care in the ency plan at least poice must conduct energency plan at least pice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not an individual facility based every 2 years; or experiences a natural or ency that requires activation of an the hospital is exempt from a required full scale exercise or individual onal exercise following the ency event. Sitional exercise every 2 years, are full-scale or functional eagraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional | EO | 39 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | | |
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| | | 34G217 | B. WING _ | | 09 | 09/04/2024 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 306 CATES STREET ROXBORO, NC 27573 | · · · · · · · · · · · · · · · · · · · | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| E 039 | a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The hexercises to test the year. The hospice (i) Participate in an is community-based (A) When a community-based functi (B) If the hospice eman-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-scommunity-based of exercise; or (B) A mock disasted (C) A tabletop exerting facilitator that include narrated, clinically-rand a set of problem messages, or preparately and a set of problem messages, or preparately disasted (iii) Analyze the homaintain document | of problem statements, , or prepared questions ige an emergency plan. Indices that provide inpatient inospice must conduct ise emergency plan twice per imust do the following: in annual full-scale exercise that id; or inity-based exercise is not it an annual individual innual exercise; or ixperiences a natural or incy that requires activation of in, the hospice is exempt from it required full-scale community ised functional exercise of the emergency event. Iditional annual exercise that inot limited to the following: icale exercise that is or a facility based functional for drill; or icise or workshop led by a ides a group discussion using a irelevant emergency scenario, in statements, directed in ared questions designed to igency plan. Ispice's response to and iation of all drills, tabletop irrigency events and revise the | E 03 | 39 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | , , | (X3) DATE SURVEY COMPLETED | |
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| E 039 | *[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF conduct exercises at twice per year. The do the following: (i) Participate in an is community-based (A) When a community-based function (B) If the [PRTF, Ho actual natural or marequires activation (facility-based functionset of the emerging (ii) Conduct an and that may include following: (A) A second full-scommunity-based of functional exercises (B) A mock (C) A tabletop of led by a facilitator ad discussion, using a emergency scenari statements, directed questions designed plan. (iii) Analyze the maintain document | 1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan annual full-scale exercise that d; or unity-based exercise is not 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. I [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based or individual, a facility-based or a 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 of [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed. | E 03 | 39 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 34G217 | B. WING | | | 09/0 | 04/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, 306 CATES STREE ROXBORO, NC | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CO | DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| E 039 | (2) Testing. The PA exercises to test th annually. The PACI following: (i) Participate in an is community-base (A) When a community-base (A) When a community-based function (B) If the PACE expressible, conduction facility-based function (B) If the PACE expressible, conducted that manyears opposite the emergency planengaging in its nextendament of the participation of the exercise following the exercise under participation of the participation of | CE organization must conduct be emergency plan at least a corganization must do the annual full-scale exercise that districts an annual individual, and exercise; or periences an actual natural or ency that requires activation of an the PACE is exempt from a 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 go rer drill; or recise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan. ACE's response to and cation of all drills, tabletop ergency events and revise the or plan, as needed. | EC | 39 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 34G217 | B. WING | i | | 09/ | 04/2024 |
| | PROVIDER OR SUPPLIER | | | 30 | TREET ADDRESS, CITY, STATE, ZIP CODE O6 CATES STREET OXBORO, NC 27573 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| E 039 | test the emergency including unannour emergency procedul CF/IID] must do the (i) Participate in an is community-based (A) When a community-based function (B) If the [LTC facility-based function (B) If the [LTC facility is exemorequired a full-scale individual, facility-based individual, facility-based following the onset (ii) Conduct an addomay include, but is (A) A second full-scommunity-based of functional exercises (B) A mock disasted (C) A tabletop exercise a facilitator includes narrated, clinically-and a set of problem essages, or prepare challenge an emerging (iii) Analyze the [LT and maintain documexercises, and emerging [LTC facility] facility *[For ICF/IIDs at §4 (2) Testing. The ICI to test the emerger The ICF/IID must desired in the community of the | replan at least twice per year, and staff drills using the ures. The [LTC facility, et following: I annual full-scale exercise that d; or unity-based exercise is not an annual individual, onal exercise. Ity] facility experiences an en-made emergency that for the emergency plan, the ent from engaging its next excommunity-based or eased functional exercise of the emergency event. Sitional annual exercise that not limited to the following: cale exercise that is for an individual, facility based or exercise or workshop that is led by a group discussion, using a relevant emergency scenario, an statements, directed exercise that is exercise or workshop that is led by a group discussion, using a relevant emergency scenario, an statements, directed exercise duestions designed to gency plan. To facility] facility's response to mentation of all drills, tabletop ergency events, and revise the exercise seed exercises and revise the exercises exercises and revise the exercise and revise the exercis | E | 039 | | | |

| | NT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
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| | | 34G217 | B. WING | | | 09 | /04/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDR 306 CATES S ROXBORO, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EAC | ROVIDER'S PLAN OF CORRI CH CORRECTIVE ACTION SI S-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| E 039 | is community-base (A) When a community-based funct (B) If the ICF/IID exman-made emerge the emergency plant engaging in its nex community-based functional exercise emergency event. (ii) Conduct an add may include, but is (A) A second full-secommunity-based functional exercise (B) A mock disaste (C) A tabletop exer a facilitator and incusing a narrated, conscipled to challer (iii) Analyze the ICF maintain document exercises, and emergency event (IIID's emergency event) and a set (C) A tabletop exer a facilitator and incusing a narrated, conscipled to challer (iii) Analyze the ICF maintain document exercises, and emergency event (C) Testing. The totest the emergency exercises annually. The (i) Participate in a frommunity-based; (A) When a conaccessible, conductive manual exercises, conductive exercises, conductive exercises, and emergency exercises. | unity-based exercise is not an annual individual, ional exercise; or. experiences an actual natural or ency that requires activation of an, the ICF/IID is exempt from a trequired full-scale or individual, facility-based following the onset of the litional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based; or er drill; or crise or workshop that is led by cludes a group discussion, linically-relevant emergency at of problem statements, and or prepared questions ange an emergency plan. E/IID's response to and tation of all drills, tabletop ergency events, and revise the cry plan, as needed. 4.102] HHA must conduct exercises and the HHA must do the following: full-scale exercise that is | E | 39 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER | | | 306 | EET ADDRESS, CITY, STATE, ZIP CODE CATES STREET XBORO, NC 27573 | | |
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| E 039 | (B) If the HHA or man-made emerof the emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an addopposite the year the exercise under partise conducted, that limited to the follow. (A) A second functional exercise. (B) A mock dis. (C) A tabletop of led by a facilitator addiscussion, using a emergency scenaristatements, directed questions designed plan. (iii) Analyze the HH documentation of a emergency events, emergency plan, as: *[For OPOs at §480 (d)(2) Testing. The to test the emerger following: (i) Conduct a paper workshop at least a led by a facilitator addiscussion, using a emergency scenarior discussion, using a emergency scenarior scenarior discussion, using a emergency scenarior. | experiences an actual natural regency that requires activation plan, the HHA is exempt from the required full-scale or individual, facility based following the onset of the ditional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section at may include, but is not be an individual, facility-based or an includes a group of an arrated, clinically-relevant or and a set of problem of dispersion of the dispersion of the dispersion of the HHA is response to and maintain and revise the HHA's seneeded. | E | 039 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 34G217 | B. WING | | | 09/ | 04/2024 |
| | PROVIDER OR SUPPLIER | | | 30 | FREET ADDRESS, CITY, STATE, ZIP CODE D6 CATES STREET OXBORO, NC 27573 | | |
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| E 039 | plan. If the OPO ex man-made emerge the emergency plar 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 tal discussion led by a clinically-relevant erof problem statement prepared questions emergency plan. (ii) Analyze the RNH maintain document and emergency emergency plan, as This STANDARD is Based on document facility failed to enscommunity/facility-based to enscommunity/facility-based to enscommunity/facility-based enscommuni | I to challenge an emergency periences an actual natural or ncy that requires activation of n, the OPO is exempt from a 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 oletop 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 is needed. Is not met as evidenced by: and review and interviews, the | EC | 039 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | . , | TIPLE CONSTRUCTION NG | ` ' | (X3) DATE SURVEY COMPLETED | |
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| | | 34G217 | B. WING | | 09 | /04/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 306 CATES STREET ROXBORO, NC 27573 | | |
| (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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| E 039 W 240 | Interview on 9/4/24 Disabilities Profess their emergency pl reviewed/discusse 2024, however, no emergency prepare INDIVIDUAL PROG | with the Qualified Intellectual sional (QIDP) confirmed all of an hazards were d during a staff meeting in April documentation of a dness exercise was available. | E 0 | | | |
| | relevant interventic toward independe This STANDARD Based on observa interview, the facilit Individual Program information to supp | ram plan must describe ons to support the individual | | | | |
| | survey on 9/3 - 9/4 side alarm mat was Review on 9/3/24 or revealed, under ad with alarm and bab | is in the home during the /24, a baby monitor and bed is noted in client #5's bedroom. of client #5's IPP dated 1/30/24 aptive equipment, "bed mat by monitor". Additional review of clude any specific information dees or their use. | | | | |
| | revealed client #5 I his bedroom to ale the middle of the n Interview on 9/4/24 Disabilities Profess | with the Home Manager (HM) has a monitor and mat alarm in rt staff in case he gets up in ight since he is a fall risk. with the Qualified Intellectual sional (QIDP) indicated client and alarm mat are used to help | | | | |

| | AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | |
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| | | 34G217 | B. WING_ | | 09 | /04/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 306 CATES STREET ROXBORO, NC 27573 | | |
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| W 240 | since he's at risk for his room in the past client's IPP does no | h he gets up in his bedroom or falls and has fallen while in st. The QIDP acknowledged the ot include any information | W 24 | 40 | | |
| W 249 | PROGRAM IMPLE CFR(s): 483.440(d | | W 24 | 49 | | |
| | formulated a client' each client must re treatment program interventions and s and frequency to se | erdisciplinary team has individual program plan, eceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program | | | | |
| | Based on observa interviews, the facil received a continuous consisting of neede as identified in the in the area of imple | is not met as evidenced by: tions, record review and lity failed to ensure client #5 bus active treatment plan ed interventions and services Individual Program Plan (IPP) ementation of dining guidelines. B audit clients. The finding is: | | | | |
| | program and in the on 9/3 - 9/4/24, clie his meals with his h towards his chest wat each meal, the coverbal prompts from With each prompt, few seconds before | time observations at the day home throughout the survey ent #5 consistently consumed head positioned downward while chewing and swallowing. Client received infrequent m staff to hold his head up. the client raised his head for a se lowering it again and the same | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING | | | COMPLETED | | |
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| W 249 | manner. Interview on 9/4/24 | with Staff C revealed client #5 aise his head up while eating | W 2 | 49 | | | |
| | revealed dining guid noted, "Staff should verbally to push his up when eating. Sta self-correctionSta [Client #5's] back be | f client #5's IPP dated 1/30/24 delines (SG1). The guidelines I encourage [Client #5] shoulders down, hold his chin aff should give him praise for ff should apply one finger to etween his shoulder blades to posture while eating" | | | | | |
| W 312 | Disabilities Profess | with the Qualified Intellectual ional (QIDP) confirmed client es are current and should be | W 3 | 12 | | | |
| | individual program specifically towards elimination of the bare employed. This STANDARD is Based on record refailed to ensure druinappropriate behavintegral part of a for | integral part of the client's plan that is directed the reduction of and eventual ehaviors for which the drugs is not met as evidenced by: eview and interview, the facility gs used to manage client #3's viors were used only as an emal active treatment plan. audit clients. The finding is: | | | | | |
| | she receives Traza Memantine 10 mg, | f client #3's record revealed done 50 mg, Sertraline 50 mg, and Gabapentin 800 mg ½ propriate behaviors. Additional | | | | | |

PRINTED: 09/06/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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| | | 34G217 | B. WING | | 09 | /04/2024 | |
| NAME OF PROVIDER OR SUPPLIER CATES STREET ICF/MR | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 306 CATES STREET ROXBORO, NC 27573 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | SHOULD BE COMPLETION | | |
| W 312 | record review revea Behavior Support F incorporated the us Interview on 9/4/24 Disabilities Profess drugs were used to inappropriate behav BSP in place that in | aled there was no formal Plan (BSP) in place that e of these drugs. with the Qualified Intellectual ional (QIDP) confirmed the | W 3 | 12 | | | |
| W 340 | other members of tappropriate protection measures that inclutraining clients and health and hygiene This STANDARD is Based on observation interviews, the facil were sufficiently trause of latex gloves. During observations day program and invarious staff wore lates in the kitchen the table. For examprogram at 12:17pr the dining table weanoted to manipulate client #4's plate whig gloves. During observations of the dining table weanoted to manipulate client #4's plate whig gloves. During observations of the dining table weanoted to manipulate client #4's plate whig gloves. During observations of the dining table weanoted to manipulate client #4's plate whig gloves just before a gloves just before a service of the dining table was not the dining table weanoted to manipulate client #4's plate whig gloves just before a glove of the dining table was not the dining table was not table table. | ust include implementing with the interdisciplinary team, we and preventive health ade, but are not limited to staff as needed in appropriate methods. In some the staff as evidenced by: tions, document review and tity failed to ensure all staff ined regarding the appropriate | W 3 | 40 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|---|----------------------------|----------------------------|--|
| | | 34G217 | B. WING _ | | 09 | /04/2024 | |
| NAME OF PROVIDER OR SUPPLIER CATES STREET ICF/MR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 306 CATES STREET ROXBORO, NC 27573 | | | | |
| (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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| W 340 | to hold cups and/or observations in the various times from wore latex gloves was preparation. The stagloves while manipal foods, and touching surfaces in the areas of the lates of the lat | pour their drinks. Further home on 9/4/24 during 6:18am - 8:00am, Staff B while completing tasks for food aff continued to wear the ulating canned foods, boxed g knobs/handles and other a. with Staff B revealed they to wear latex gloves while duties and during meal onal interview on 9/4/24 with ome staff choose to wear in the kitchen. The staff a preference." If the facility's policy for Use of (effective 2/19/21) revealed, is not negate the need for hand ould always be washed after use hand sanitizer." If the policy noted, "Disposable, thall be used as follows: amination with blood, blood ble blood, drainage from wounds and when participating a likely to result in blood or the review of the policy did oves should be used in the described. with the Qualified Intellectual ional (QIDP) confirmed latex be used as indicated in the re not been trained to routinely forming cooking tasks in the | W 34 | 40 | | | |

PRINTED: 09/06/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--|--|--|--|--|
| 34G217 | | B. WING | | | 09/04/2024 | | |
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| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | (EACH CORRECTIVE ACTION S | CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE | | | |
| DRUG ADMINISTR CFR(s): 483.460(k) The system for drug that all drugs, include self-administered, at This STANDARD is Based on observatinterviews, the facilimedications were at This affected 1 of 4 receiving medication. During morning obstadministration in the client #4 ingested Town Metformin, Flomax, and Tegretol. No ottobserved to be administration to be administration observed to be administration of the Medication Technedications observed to have the Medication observed. Review on 9/4/24 ophysician's orders of 7/1/24 noted an order once daily at 7:30an | g administration must assure ding those that are are administered without error. It is not met as evidenced by: sions, record review and sity failed to ensure all administered without error. It is clients (#4) observed ans. The finding is: servations of medications are home on 9/4/24 at 8:39am, aradjenta, Glimepiride, are Enalopril, Docusate Sodium ther medications were an inistered during this time. With the Home Manager (also annician) confirmed the ared were the medications client are in the morning. If client #4's most current are for Aspirin low chew 81 mg m. | | | | | | |
| confirmed client #4' orders indicate he s the morning. FOOD AND NUTRI CFR(s): 483.480(a) | s most current physician's should receive Aspirin 81 mg in TION SERVICES (1) | W 4 | 460 | | | | |
| | SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa DRUG ADMINISTR CFR(s): 483.460(k) The system for drug that all drugs, includ self-administered, a This STANDARD is Based on observat interviews, the facili medications were a This affected 1 of 4 receiving medication During morning obs administration in the client #4 ingested T Metformin, Flomax, and Tegretol. No otl observed to be adm Interview on 9/4/24 the Medication Tech medications observ #4 normally receive Review on 9/4/24 or physician's orders s 7/1/24 noted an ord once daily at 7:30ar Interview on 9/4/24 confirmed client #4' orders indicate he s the morning. FOCD SNU NUTRI CFR(s): 483.480(a) | TREET ICF/MR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 4 clients (#4) observed receiving medications. The finding is: During morning observations of medications administration in the home on 9/4/24 at 8:39am, client #4 ingested Tradjenta, Glimepiride, Metformin, Flomax, Enalopril, Docusate Sodium and Tegretol. No other medications were observed to be administered during this time. 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