

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

PRINTED: 10/17/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEE FOREST HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1209 PELLHAM DR LAURINBURG, NC 28352</b>		
(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 369	<p><b>DRUG ADMINISTRATION</b> CFR(s): 483.460(k)(2)</p> <p>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 administer medications as ordered by physician for 1 of 4 audit clients (#1). The finding is:</p> <p>During medication administration on 10/9/24 at 7:05am, client #1 received a 75mg dose of Levothyroxin from Staff F. An additional observation on 10/9/24 at 7:23am, revealed client #1 ate scrambled eggs for breakfast.</p> <p>Record review on 10/9/24 of client #1's Physician's Orders from 6/5/24 revealed Levothyroxin should be taken 30 minutes before breakfast.</p> <p>Interview on 10/9/24 with Staff F revealed the clients ate breakfast early today instead of at 7:30am because they have to transport a client to the doctor.</p> <p>Interview on 10/9/24 with the Nurse acknowledged Levothyroxin needed to be given on an empty stomach and to wait 30 minutes before breakfast.</p>	W 369			
W 441	<p><b>EVACUATION DRILLS</b> CFR(s): 483.470(i)(1)</p> <p>and under varied conditions to- This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills using varying times and conditions. The finding is:</p>	W 441			

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.

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

PRINTED: 10/17/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEE FOREST HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1209 PELLHAM DR LAURINBURG, NC 28352</b>		
(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 441	Continued From page 1  Record review on 10/9/24 revealed fire drills revealed the following:  First Shift Drills 10/3/23 at 2:12pm 1/4/24 at 9:10am 4/3/24 at 2:08pm 7/2/24 at 9:25am 10/8/24 at 9:53am  Interview on 10/9/24 with the Home Manager revealed she did not realize the drill times had to be varied when she reviewed the documents each month.  Interview on 10/9/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed she reviewed the fire drills monthly.	W 441			
W 454	INFECTION CONTROL CFR(s): 483.470(I)(1)  The facility must provide a sanitary environment to avoid sources and transmission of infections.  This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that food was not retained after contamination. This affected 1 of 4 audit clients (#6). The finding is:  During observations in the home on 10/8/24 at 5:43pm, client #6 requested wafer cookies from Staff B. Client #6 was observed reaching in the box of wafers and grabbed a large handful. Staff B was heard telling client #6, "Do not get the whole box." Staff B then closed the box of waters	W 454			

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

PRINTED: 10/17/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEE FOREST HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1209 PELLHAM DR LAURINBURG, NC 28352</b>		
(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 454	Continued From page 2 and returned it to the pantry.  Interview on 10/9/24 with the Behavior Specialist revealed if client #6 reached into an item that's shared food, it should be discarded once contaminated.	W 454			