CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 INTERMENT OF DEFICIENCES AND PLAN OF CORRECTION (1) PROVIDER/PUERCUA DENTIFICATION NUMBER (2) MULTIPLE CONSTRUCTION A BUILDING (2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING (2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING (2) MULTIPLE CONSTRUCTION A BUILDING A BUILDIN			AND HUMAN SERVICES				FORM	APPROVED
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338 COOPER DRIVE WINTERVILLE, NO 28590 CMUID PREFIX TVG SUMMARY STATEMENT OF DEFICIENCIES REGULTIONY OR LISCIDENTIFYING INFORMATION) D PREFIX TVG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CMUID DEFICIENCY W 249 PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) W 249 W 249 PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) W 249 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. W 249 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 4 audit clients (#9) received a continuous active treatment program consisting of needed interviews and services as identified in the individual Program Plan (IPP) in the area of adaptive equipment. The finding is: Observations throughout the survey asses, and staff did not prompt him to wear glasses, and staff did not is responsible for visually inspecting his glasses each morning, and staff should ancourage him to wear his glasses and to ensure he wears his glasses. The medication morning is responsible for visually inspecting his glasses each morning, and staff should ancourage him to wear his glasses Interview on 11/19/24 with Staff B revealed client	34G261		B. WING			11/19/2024		
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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 1 of 4 audit clients (#9) received a continuous active treatment program consisting of needed interviews, the facility failed to ensure 1 of 4 audit clients (#9) received a continuous active treatment program Plan (PP) in the area of adaptive equipment. The finding is: Observations throughout the survey on 11/18 - 11/19/24 in the home revealed client #9 participating in table activities, home routine activities, and dining. He did not wear glasses, and staff did not prompt him to wear glasses. Review on 11/18/24 of client #9's IPP, dated 2/29/24, revealed he wears glasses. In addition, he has ongoing guidelines to maintain his glasses and to ensure he wears his glasses. The medication monitor is responsible for visually inspecting his glasses each morning, and staff should encourage him to wear his glasses throughout the day. Interview on 11/19/24 with Staff B revealed client	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF) BE	COMPLETION
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		2/29/24, revealed h he has ongoing guid and to ensure he we medication monitor inspecting his glass should encourage h	e wears glasses. In addition, delines to maintain his glasses ears his glasses. The is responsible for visually ses each morning, and staff nim to wear his glasses					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		#9 does have glass	es, but he often does not keep			TITIE		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

PRINTED: 11/21/2024

		AND HUMAN SERVICES			FORM	11/21/2024 APPROVED		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		34G261	B. WING		11/19/2024			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
SCI-EAS	т		338 COOPER DRIVE WINTERVILLE, NC 28590					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
W 249	Continued From pa them on.	ge 1	W 249					
		24 with Staff C revealed client does not prefer to wear them.						
	Intellectual Disabilit	24 with the Qualified ties Professional (QIDP) nas glasses. Staff should hem on.						
W 460	client #9 has glasse them on. However, wear his glasses ar		W 460					
	Each client must re well-balanced diet i specially-prescribed	ncluding modified and						
	Based on observat interviews, the facili	s not met as evidenced by: tions, record review and ity failed to ensure 1 of 4 audit d his specially prescribed diets nding is:						
	7:50am, client #7 w oatmeal, three turke piece of toast. The	s in the home on 11/19/24 at vas served and consumed ey sausage links and one sausage links and toast were Client #7 did not have any eal.						
	Program Plan (IPP)	4 of client #7's Individual), dated 6/20/24, revealed a controlled diet with chopped						

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If continuation sheet Page 2 of 3

		AND HUMAN SERVICES				FORM	11/21/2024 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G261	B. WING			11/19/2024			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE				
SCI-EAS	т		338 COOPER DRIVE WINTERVILLE, NC 28590						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD E	BE	(X5) COMPLETION DATE		
W 460	Continued From pa consistency. Review on 11/19/24 orders, dated 8/23/2 all food textured to Interview on 11/19/2 #7 should have cho Interview on 11/19/2 Disabilities Profess	ige 2 4 of client #7's physician 24, revealed he should have chopped consistency. 24 with Staff A revealed client	W 46	DEFICIEN					

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Facility ID: 922524

If continuation sheet Page 3 of 3