CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		34G033	B. WING			11/	06/2024
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTUDI	DGE ROAD			3	301 SOUTHRIDGE RD		
300111	DGE ROAD			•	JAMESTOWN, NC 27282		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 125	PROTECTION OF CI CFR(s): 483.420(a)(3		W	125	5		
	Therefore, the facility individual clients to ex- of the facility, and as including the right to f to due process. This STANDARD is r Based on observation failed to ensure that 1 treated with dignity ar of incontinence paddi During observations i 3:45 PM, client #4 wa recliner with an incon under the client's bod revealed a chair cove the incontinence pad the recliner in the livir During observations i 7:33 AM, client #4 wa independently walk a near the window to si Continued observation pad in the recliner to	nd respect regarding the use ng. The finding is: In the home on 11/5/24 at is observed sitting in a tinence pad clearly visible y. Further observation r on the same recliner with sitting of the chair cover in ng room. In the home on 11/6/24 at is observed to stand and few steps to a nearby chair t for a better view outside. In revealed the incontinence become visible underneath					
	client #4 to return to t	ner observation revealed he recliner after the on the incontinence pad.					
	Professional (QIDP) of incontinence pads are in common living area the QIDP revealed cli schedule which invali	e not to be used in the home as. Continued interview with ent #4 is on a toileting					
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
		34G033	B. WING		1,	1/06/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHRI	DGE ROAD			01 SOUTHRIDGE RD AMESTOWN, NC 27282		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
W 125	interview with the QII padding when used in	e 1 DP revealed if incontinent n the home is only used in psequent interview confirmed	W 125			
W 249	that use of the incont clients' right to dignity	inence pads violates the /. ENTATION	W 249			
		ndividual program plan, ive a continuous active				
	interventions and ser and frequency to sup	vices in sufficient number port the achievement of the n the individual program				
	Based on observation interviews, the facility clients (#2 and #4) per implemented relative	not met as evidenced by: n, record review and r failed to ensure 2 of 5 erson-centered plan was to their identified goals for pment. The finding is:				
	A. The facility failed a during personal care:	to ensure client #2's privacy				
	9:10 AM revealed sta bathroom to brush his observation revealed with the bathroom do to be visible sitting or Further observation r	oup home on 11/06/24 at oup home on 11/06/24 at ff to assist client #2 to the s teeth. Continued client #2 to sit on the toilet or open wide enough for him in the toilet from the hallway. evealed the DSP to be ng items for client #2 in his				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/08/2024 APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G033	B. WING				11/	06/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE	, ZIP CODE		
SOUTHRI	DGE ROAD				301 SOUTHRIDGE RD JAMESTOWN, NC 27282			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI ID TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
W 249	Continued From page	2	w	249	9			
	Continued review of t revealed the following assist staff with cleari housekeeping, recrea after entering the batt in the mornings and e the PCP for privacy g close the bathroom de the door. Interview on 11/06/24 Staff (DSP) revealed bathroom to assist br Continued interview v had him sit on the toil which inadvertently q interview with the DS bathroom to retrieve of and she failed to closs Interview with on 11/0 intellectual disabilities revealed client #2's P interview with the QIE been trained on client interview at the door during personal care. B. The facility failed to to prescribed adaptive Observation in the gree PM revealed client #2 meal consisting of me	<ul> <li>(PCP) dated 03/01/2024.</li> <li>the PCP for client #2</li> <li>g goals: personal space,</li> <li>ng his glasses,</li> <li>ttion, privacy-close the door</li> <li>proom, safety, and exercise</li> <li>evenings. Further review of</li> <li>oal clarified that staff should</li> <li>bor if client #2 fails to close</li> <li>with the Direct Support</li> <li>she assisted client #2 to the</li> <li>ush him with toothbrushing.</li> <li>with the DSP revealed she</li> <li>et clothed to brush his teeth</li> <li>ued him to urinate. Further</li> <li>P revealed she left the</li> <li>clean clothing for client #2</li> <li>e the door.</li> <li>26/24 with the Qualified</li> <li>a professional (QIDP)</li> <li>CP is current. Continued</li> <li>OP revealed all staff have</li> <li>c #2's PCP. Further</li> <li>OP revealed the DSP should</li> <li>to ensure client #2's privacy</li> </ul>						

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/08/2024 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G033	B. WING			_	11/	06/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SOUTHRIDGE ROAD					301 SOUTHRIDGE RD JAMESTOWN, NC 2728	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	observation revealed setting that consisted a fork, case knife, spo observation revealed would allow them to u meat loaf. Subseque client #2 to comply wi meatloaf cut with the observation revealed returned to the kitcher Observation in the gro AM revealed client #2 meal consisting of on- of toast with butter an coffee, 1 cup of 2% m and one cup of water- revealed client #2 to h consisted of a regular beverage cups, a fork napkin. Further obse client #2 if he would a knift to cut his slice of observation revealed offer to have his toast Final, observation rev returned to the kitcher Review of records on Nutritional Assessmen Continued review of to a regulary diet with no to an allergy, a rocker assistance in using it. Interview with the QIE client #2's NA is current the QIDP confirmed of	client #2 to have a place of a regular plate, two cups, oon, and napkin. Further staff to ask client #2 if he use a Rocker knift to cut his nt observation revealed th the offer to have his rocker knife. Final, the rocker knife to be n. oup home on 11/6/24 at 8:15 to participate in a breakfast e scrambled egg, one piece d grape jelly, 1 cup of hilk, 1 cup of of grape juice . Continued observation have a place setting that plate, one coffee cup, three to case knife, spoon, and rvation revealed staff to ask illow them to use a Rocker toast. Subsequent client #2 to comply with the cut with the rocker knife. ealed the rocker knife to be n. 11/6/24 revealed a ht (NA) dated 2/29/2024. he NA reveals client #2 has o nuts or nut products , due thife and requires	W	249	9			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/08/2024 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		34G033	B. WING _				11/	06/2024
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STAT	TE, ZIP CODE		
SOUTHRI	DGE ROAD				1 SOUTHRIDGE RD			
				JA	MESTOWN, NC 27282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 249	Continued From page providing assistance t		W 2	249				
		o ensure client #4s access e equipment during meals:						
	PM revealed client #4 meal consisting of me water and a condimer observation revealed setting that consisted a fork, case knife, spo observation revealed would allow them to u meat loaf. Subseque	the rocker knife to be						
	AM revealed client #4 meal consisting of one of toast with butter and coffee, 1 cup of 2% m and one cup of water. revealed client #4 to h consisted of a regular beverage cups, a fork napkin. Further obse client #4 if he would a knift to cut his slice of observation revealed offer to have his toast Final, observation rev returned to the kitcher Review of records on	client #4 to comply with the cut with the rocker knife ealed the rocker knife to be n.						

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		10. 0938-039	
AND PLAN OF CORRECTION				A. BUILDING			
		34G033	B. WING		1'	1/06/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
SOUTHRIDGE ROAD			301 SOUTHRIDGE RD				
				JAMESTOWN, NC 27282			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
W 249	Continued From pag	e 5	W 24	9			
		the NA reveals client #4 has					
		diet, 49 grams of protien					
	daily, uses a rocker l						
	beverage cup/glasse	5.					
W 369			W 36	99			
	CFR(s): 483.460(k)(2	2)					
	-	administration must assure					
	that all drugs, includi	ng those that are e administered without error.					
		not met as evidenced by:					
	Based on observation	on, record review and					
		failed to ensure all drugs					
		ithout error for 4 of 6 clients observed during medication					
	administration. The f	-					
	A. The facility failed t	to ensure all drugs were					
		error for client #1. For					
	example:						
	Observation in the gr	roup home on 11/6/24 at 8:27					
		d client #1 to sanitize hands					
		ication administration in the ntinued observation revealed					
		#1's medication basket from					
		it on the desk. Further					
		d staff to crush medications,					
	pour liquid medication medications into a bo	ns, and place non crushed					
	Subsequent observa	····	1				

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PRINTED: 11/08/2024 FORM APPROVED

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_\_\_ 34G033 B. WING 11/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **301 SOUTHRIDGE RD** SOUTHRIDGE ROAD JAMESTOWN, NC 27282 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 369 Continued From page 6 W 369 administer the morning medications to client #1 feeding the client applesauce containing medications. Review of records for client #1 on 11/6/24 revealed physician orders dated 10/1/24. Review of the 10/1/24 physician orders revealed medications to administer at 8:00 AM to be Benztropine tab 0.5 MG, Lacosamide tab 100MG, Lactulose Solution 10/GM/15 Solution, Loratadine 5MG/5ML Syrup Solution, Nitrofurantoin MONO-MCR 100MG, Omeprazole cap 20MG, Tamsulosin cap 0.4MG, Therems-M tab, and Vitamin B-12-tab 1000MCG, and chocolate Ensure. Staff were not observed to provide client #1 with chocolate Ensure which is prescribed twice daily with meals at 8:00 AM and 5:00 PM Interview with the facility nurse on 11/6/24 confirmed the 10/1/24 physician orders for client #1 to be current. Continued interview with the facility nurse revealed that staff should administer medications as prescribed. B. The facility failed to ensure all drugs were administered without error for client #2. For example: Observation in the group home on 11/6/24 at 9:40 AM revealed a pink tablet on the floor in the medication administration room next to the trash can. Continued observations revealed the residential manager (RM) and gualified intellectual disabilities professional (QIDP) identified the tablet to be Carbamazepine chew 100MG to be prescribed to client #2. Review of records for client #2 on 11/6/24 revealed physician orders dated 10/1/24. Review

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

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PRINTED: 11/08/2024

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/08/2024 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G033	B. WING		11	/06/2024
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHRI	DGE ROAD			1 SOUTHRIDGE RD MESTOWN, NC 27282		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 369	of the 10/1/24 physici to be prescribed Carb three times daily at 8: PM. Interview with the QIE Carbamazepine chew belonged to client #2. the QIDP confirmed th an additional dose of 100MG per facility nu times and not knowing medication ended up Interview with the faci confirmed the 10/1/24 #2 to be current. Com facility nurse revealed medications as presc supplements. C. The facility failed to administered without example: Observation in the gro AM revealed staff and and prepare for medic medication room. Cor staff to remove client the closet and place if observation and t medication whole with Restasis EMU 0.05% Review of records for	an orders revealed client #2 bamazepine chew 100MG c00 AM, 2:00 PM, and 8:00 DP on 11/6/24 confirmed that v 100MG found on the floor . Continued interview with hat client #2 will not receive Carbamazepine chew irse due to administration g how and when the on the floor. ility nurse on 11/6/24 4 physician orders for client tinued interview with the d that staff should administer ribed including o ensure all drugs were error for client #4. For oup home on 11/6/24 at 7:54 d client #4 to wash hands cation administration in the ntinued observation revealed #4's medication basket from it on the desk. Further d staff administered client the client took the h water and staff instilled o eyedrops to both eyes.	W 369			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 11/08/2 FORM APPRO OMB NO. 0938-0	VED
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE SURVEY COMPLETED	001
		34G033	B. WING		_	11/06/2024	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
SOUTHRI	DGE ROAD		-	01 SOUTHRIDGE RD AMESTOWN, NC 27282	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)	DATE	
W 369	medications to admin Vitamin D 125 MCG ( 0.05% drop, and Lote Staff were not observe Lotemax SM Gel 0.38 daily instilling 1 drop i 8:00PM. Interview with the faci confirmed the 10/1/24 #4 to be current. Cont facility nurse revealed medications as presce D. The facility failed to administered without example: Observation in the gro AM revealed staff and medication room and for medication admini observation revealed medication basket fro the desk. Further obs administered client #5 punching hand over ho observations revealed medications whole wi prescribed eyedrops to Review of records for revealed physician or of the 10/1/24 physici medications to admin Vitamin D3 25 MCG ( 20MG, Docusate SOD antioxid, Calcium vita	ister at 8:00 AM to be 5000IU), Restasis EMU max SM Gel 0.38% drop. ed to provide client #4 with 3% drops prescribed twice in both eyes at 8:00AM and ility nurse on 11/6/24 4 physician orders for client tinued interview with the 4 that staff should administer ribed. o ensure all drugs were error for client #5. For bup home on 11/6/24 at 8:04 d client #5 to walk in the sanitize hands and prepare istration. Continued staff to remove client #5's im the closet and place it on ervations revealed staff 5's morning medications hand in pill cup. Subsequent d the client took all morning th water and staff instilled 2 to client #5 on 11/6/24 ders dated 10/1/24. Review an orders revealed ister at 8:00 AM to be 1,000IU), Furosemide tab D cap 100MG, Certavite	W 369				

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		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE				
		34G033	B. WING			11/	06/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SOUTHRI	DGE ROAD				01 SOUTHRIDGE RD AMESTOWN, NC 27282		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
W 369	Solution 0.15% drop, 2% drop. Staff were r client #5 with Dorzola prescribed three time right eye at 8:00AM, 2 Interview with the fac confirmed the 10/1/24 #5 to be current. Con	and Dorzolamide Solution not observed to provide mide Solution 2% drops s daily instilling 1 drop in 2:00 PM and 8:00PM. ility nurse on 11/6/24 4 physician orders for client tinued interview with the d that staff should administer	W	369			

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