DEPART	MENT OF HEALTH	AND HUMAN SERVICES		•	FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G239	B. WING _		C 11/21/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THOMAS	S DECATUR HOME			7559 DECATUR DRIVE	
				FAYETTEVILLE, NC 28303	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (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 COMPLÉTION
W 000	INITIAL COMMENT	ſS	W 00	00	
		was completed on 11/21/24 23140. The complaint was			
	the facility impleme	ardy was identified however nted a Plan of Protection and ardy was removed, and ciencies were cited.			
W 122	on 6/4/24 and 9/3/2 corrected, however W347 remained ou	IONS	W 12	22	
	Therefore the facilit This CONDITION The facility failed to subjected to abuse	isure the rights of all clients. ty must is not met as evidenced by: o ensure clients were not or neglect (W127) and ensure s are thoroughly investigated			
	practices resulted in	ect of these systematic n the facility's failures to andated services of client ents.			
	11/21/24 relative to its clients from elop	ardy was determined on the facility's inability to protect pements and engaging in high is injuries/or death, while f-harm.			
	the facility impleme	ardy was identified however nted a Plan of Protection and			
I ABORATORY	V DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	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.

PRINTED: 12/06/2024

		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIE	LE CONSTRUCTION		0. 0938-039 TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			· /	MPLETED	
						С	
		34G239	B. WING		11/21/2024		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THOMAS	S DECATUR HOME			7559 DECATUR DRIVE FAYETTEVILLE, NC 28303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
W 122	Continued From pa	-	W 122	2			
W 149	condition level defin		W 149				
	CFR(s): 483.420(d))(1)					
	policies and proceed mistreatment, negle This STANDARD i Based on record re facility failed to ass were implemented	ect or abuse of the client. s not met as evidenced by: eview and interviews, the ure its policies and procedures to prevent neglect and ensure pervision were followed for 1					
	support plan (BSP) self-harm (including non-compliance an leave (AWOL) as s Client #'s 3 objective rate of disruptive be episodes per month Client #3 was prese Clonazepam, Lithiu Gabapentin for his Bipolar Disorder, P Mild Intellectual Dis Disorder. He had p hospitalizations, with to 6/26/24. During to client #3's psychiat	1/21/24 of client #3's behavior dated 10/1/24 revealed g threats of suicide), d absence without official ome of his targeted behaviors. we were: By 10/1/25, client #3's ehavior will be reduced to zero h for 6 consecutive months. cribed Uzedy, Escitalopram, im Carb, Risperidone and behaviors and diagnosis of ost Traumatic Stress Disorder, sability and Schizoaffective revious psychiatric th one as recently as 6/21/24 this hospitalization, some of ric medications: Divalproex, za, Melatonin and Prozasin,					
	Preventive Strategi	ealed the BSP identified es as: ats of self-harm, allow him to					

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		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DAT COM	E SURVEY IPLETED
		34G239	B. WING				C 21/2024
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THOMAS	SS DECATUR HOME				559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 149	talk about his feelin actively engage in s staff should interact aggression. If he be self-injurious behavi immediately block a behavior. A pillow o prevent injury. Whe staff is to verbally e a 10-minute period. if he would prefer a Attempted AWOL- I all times, be sure to behavior. Let him kt concerns and redires staff will be trained Manager or Qualifie Professional (QIDP implementation of p Record review on 1 reports revealed nu 2024 to elope from lay down in the road repeatedly on the g - On 4/27/24 at 10:0 finishing up meds, o door, prompting Sta Client #3 fell out in fu up when Staff K tries minutes, he got up home. Client #3 cor attempts to leave th - On 8/1/24 at 10:15 threat to staff. - On 10/20/24 at 10	 and ensure he does not self-harm or suicide. Only one t with him, during periods of egins to engage in viors (SIB), staff should and redirect to prevent this or towel could be used to en non-compliant, only one engage him, no more than 2x in . Do not over prompt. Ask him nother activity. Maintain line of sight on him at o avoid drawing attention to the now you will document his ect him to another activity. All by the Psychologist, Program ed Intellectual Disabilities P) in the appropriate orogram procedures. 1/21/24 of client #3's incident umerous attempts since April, the home, threaten suicide, d, and to bang his head iround. 00 am, Staff K recorded while client #3 went outside of the aff K to follow him outside. the street and refused to get ed to assist him. After a few and came back inside the ntinued to make repeated 	W -	149			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G239	B. WING				C 21/2024
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
THOMAS	S DECATUR HOME				7559 DECATUR DRIVE FAYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 149	stopped by staff. Cl head on the ground pillow to prevent fur redirected to his roo would "kill himself". him until he fell asle - On 11/14/24 at 7:3 elopement. - On 11/15/24 at 12 attempted elopeme he successfully elop - On 11/19/24 at 7:3 the facility. Interview on 11/21/2 (HM) revealed she elopements and ha week to notify him o Interview on 11/21/2 was aware of the pr received the incider incidents today. The receive messages f she contacted him was already in bed; 11/15/24, "If he was something, when re assume he rememi confirmed he respon messages and cam morning. Interview on 11/21/2 revealed they have supports for client # The QIDP Supervis wanted to appeal the	ient #3 then began to hit his l, prompting staff to use a ther harm. Client #3 was om, when he told staff he Staff stayed in the room with eep. 30 pm, client #3 attempted an 2:00 pm, client #3 an nt and later during third shift,	W -	149			

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STATE DEAN OF CORRECTION [X1] PROVIDERSUPPLICENCIA JUDITIFICATION NUMBER: X2] MULTIPLE CONSTRUCTION A BUILDING (X2] MULTIPLE CONSTRUCTION A BUILDING (X3] DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLICENCIA THOMAS S DECATUR HOME 346239 STREET ADDRESS, CITY, STATE, 2IP CODE TSSE DECATUR DRIVE FAYETTEVILLE, NC 2830 III/21/2024 IMME OF PROVIDER OR SUPPLICENCIA TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREFX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CONSTRUCTION OF CLOCENTPINION INFORMATION) III/21/2001 W 149 Continued From page 4 been approved for funding in another program. The QIDP Supervisor acknowledged the guardian was already trying to coordinate discharging client #3 from the group home. W 149 W 149 Continued From page 4, been approved for funding in another program. The QIDP Supervisor. A Safety Plan was put in place, which entailed a 1:1 immediately assigned to client #3 from the group home. W 149 Immediate Jeopardy (LJ) was identified on 11/21/24 at 5:00 pm and before starting upcoming shifts; staff will ensure that all door alarms to exterior doors and client #3's bedroom door is kept open and checked and documented hourly by staff. All incidents will be immediately reported to the supervisor, who will also notify the nurse if client #3 exhibits suicidal behaviors. Staff will ensure a person transfer whenever client #3 is non-compliant in laying in the road, to ensure this safety. Staff will contact the police to report elopements, when they are unable to get client #3 to staff will ensure the integrated, coordinated and momitored by a qualified intellectual disability professional who-			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/06/2024 APPROVED 0938-0391
346239 B. WING 11/2/12024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TS99 DECATUR HOME STREET ADDRESS, CITY, STATE, ZIP CODE IMMED FOR DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Immediate DEFICIENCY Immediate DEFICIENCES PREEX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPARISON CMI D COMPARISON COMPARISON <td>STATEMENT</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>` '</td> <td></td> <td>LE CONSTRUCTION</td> <td>(X3) DATI COM</td> <td>E SURVEY PLETED</td>	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STRE, ZIP CODE THOMAS 5 DECATUR HOME 759 DECATUR DRIVE FAST DECATURE CODE (M1)D TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE RECEDED BY PLL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PIC PREFIX (EACH DEFICIENCY) PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) COMMETTION SUBJECT W 149 Continued From page 4 UI been approved for funding in another program. The QIDP Supervisor acknowledged the guardian was already trying to coordinate discharging client #3 from the group home. W 149 Immediate Jeopardy (IJ) was identified on 11/21/24 at 5:00 pm and brought to the attention of the Home Manager, QIDP and QIDP Supervisor. A Safety Plan was put in place, which entailed a 1:1 immediately assigned to client #3, staff retrained on the his BSP and the Missing Person Policy by the home manager and before starting upcoming shifts; staff will ensure that all door alarms to exterior doors and client #3 bedroom door is kept open and checked and documented hourly by staff. All incidents will be immediately reported to the supervisor, who will also notify the nurse if client #3 exhibits suicidal behaviors. Staff will engage a 2 person transfer whenever client #3 is non-compliant in laying in the road, to ensure his safety. Staff will contact the police to report elopements, when they are unable to get client #3 to return to the home. The Plan of Protection was reviewed and accepted by the survey team on 11/21/24. W 159 W 159 QLP CFR(s): 483.430(a) W 159 Each client #3 cative treatment program must be integrated, coordinated and monitored by a qualified intellectual Disability professional who- This STANDARD is not met as evidenc			34G239	B. WING	i			
THOMAS S DECATUR HOME FAYETTEVILLE, NC 28303 (M) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDENTIFY ING INFORMATION) ID PROVIDENTIFY INFORMATION ID PROVIDENTIFY INFORMATION ID PROVIDENTIFY INFORMATION) ID PROVIDENTIFY INFORMATION ID PROVIDENTIFY INFORMATION ID PROVIDENTIFY INFORMATION ID PROVIDENTIFY INFORMATION ID PROVID	NAME OF F	PROVIDER OR SUPPLIER						
Preferx TxG (EACH OBSECTIVE ACTION ENOUND BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TxG (EACH CORRECTIVE ACTION ENOUNTE DEFICENCY) Convision DEFICENCY W 149 Continued From page 4 been approved for funding in another program. The QIDP Supervisor acknowledged the guardian was already trying to coordinate discharging client #3 from the group home. W 149 W 149 Immediate Jeopardy (IJ) was identified on 11/21/24 at 5:00 pm and brought to the attention of the Home Manager, QIDP and QIDP Supervisor. A Safety Plan was put in place, which entailed a 1:1 immediately assigned to client #3, staff retrained on the his BSP and the Missing Person Policy by the home manager and before starting upcoming shifts; staff will ensure that all door alarms to exterior doors and client #3's bedroom door is kept open and checked and documented hourly by staff. All incidents will be immediately reported to the supervisor, who will also notify the nurse if client #3 exhibits suicidal behaviors. Staff will engage a 2 person transfer whenever client #3 is non-compliant in laying in the road, to ensure his safety. Staff will contact the police to report elopements, when they are unable to get client #3 to return to the home. The Plan of Protection was reviewed and accepted by the survey team on 11/21/24. W 159 W 159 Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record review and interviews, the facility's Qualified intellectual disability softasional disability W 159	THOMAS	S DECATUR HOME						
been approved for funding in another program. The QIDP Supervisor acknowledged the guardian was already trying to coordinate discharging client #3 from the group home. Immediate Jeopardy (U) was identified on 11/21/24 at 5:00 pm and brought to the attention of the Home Manager, QIDP and QIDP Supervisor. A Safety Plan was put in place, which entailed a 1:1 immediately assigned to client #3, staff retrained on the his BSP and the Missing Person Policy by the home manager and before starting upcoming shifts; staff will ensure that all door alarms to exterior doors and client #3's bedroom door is kept open and checked and documented hourly by staff. All incidents will be immediately reported to the supervisor, who will also notify the nurse if client #3 exhibits suicidal behaviors. Staff will engage a 2 person transfer whenever client #3 to return to the home. The Plan of Protection was reviewed and accepted by the survey team on 11/21/24. W 159 QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record review and interviews, the facility's Qualified Intellectual Disabilities	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
Professional (QIDP) failed to ensure the active treatment program for 1 of 3 audit clients (#3) was coordinated, integrated and monitored as needed. The finding is:		been approved for f The QIDP Supervis was already trying t #3 from the group h Immediate Jeopard 11/21/24 at 5:00 pm of the Home Manag Supervisor. A Safet entailed a 1:1 imme staff retrained on th Person Policy by the starting upcoming s door alarms to exte bedroom door is ke documented hourly immediately reporte also notify the nurse behaviors. Staff will whenever client #3 the road, to ensure the police to report unable to get client Plan of Protection v the survey team on QIDP CFR(s): 483.430(a) Each client's active integrated, coordina qualified intellectual This STANDARD is Based on record re facility's Qualified Ir Professional (QIDP treatment program was coordinated, in	funding in another program. or acknowledged the guardian o coordinate discharging client nome. y (IJ) was identified on and brought to the attention ger, QIDP and QIDP y Plan was put in place, which ediately assigned to client #3, he his BSP and the Missing e home manager and before shifts; staff will ensure that all rior doors and client #3's pt open and checked and by staff. All incidents will be ed to the supervisor, who will e if client #3 exhibits suicidal engage a 2 person transfer is non-compliant in laying in his safety. Staff will contact elopements, when they are #3 to return to the home. The was reviewed and accepted by 11/21/24. treatment program must be ated and monitored by a I disability professional who- is not met as evidenced by: eview and interviews, the intellectual Disabilities) failed to ensure the active for 1 of 3 audit clients (#3) tegrated and monitored as					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		BERTH IO, THOM NOWBER.	A. BUILDI	NG		C
		34G239	B. WING		11/2	21/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7559 DECATUR DRIVE		
THOMAS	S DECATUR HOME			FAYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 159	Continued From pa	ge 5	W 1	59		
W 195	ensure direct care s clients (#3) behavio implemented consis inappropriate behav ACTIVE TREATME CFR(s): 483.440 The facility must en	stently as written to redirect viors.	W 19	95		
	The facility must en treatment services CONDITION is not ensure specific objectiont's needs (W19 received a continuous which includes agging implementation of a generic training and the acquisition of the client to function with	s not met as evidenced by: nsure that specific active requirements are met. This met as evidenced by: To ectives necessary to meet the 06), to ensure that each client us active treatment program, ressive, consistent a program of specialized and d treatment directed towards e behaviors necessary for the th as much self-determination as possible (W196 and				
W 196	resulted in the facili statutorily mandated clients. ACTIVE TREATME CFR(s): 483.440(a) Each client must re		W 15	96		

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		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G239	B. WING				C 21/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS	S DECATUR HOME				559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 196	specialized and ger services and related subpart, that is dire- (i) The acquisition the client to function determination and i (ii) The prevention or loss of current op This STANDARD is ased on interviews facility failed to assu consistent active tre provided for client # Review on 11/21/24 Program Plan (IPP) Support Plan (BSP) targeted behaviors self-harm, self-injur absence without off Cross reference W2 that objectives were sufficient intervention visual supervision of communicating self from the home and threatening suicide. INDIVIDUAL PROG CFR(s): 483.440(c) The comprehensive include nutritional s This STANDARD is	entation of a program of heric training, treatment, health d services described in this cted toward: of the behaviors necessary for n with as much self independence as possible; and or deceleration of regression btimal functional status. s not met as evidenced by: and record reviews, the ure an aggressive and eatment program was 43. The finding is: 4 of client #3's Individual 0 dated 5/15/24 and Behavior 0 dated 10/1/24 identified included threatening ious behavior and attempted ficial leave (AWOL). 249. The team failed to assure e implemented and that ons were used to maintain of client #3, when 5-harm language, elopements when laying in the road, GRAM PLAN ((3)(v) e functional assessment must tatus. s not met as evidenced by:	W 1				
W 217	threatening suicide. INDIVIDUAL PROC CFR(s): 483.440(c) The comprehensive include nutritional s This STANDARD is	GRAM PLAN (3)(v) e functional assessment must tatus.	W 2	217			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G239	B. WING				C 21/2024
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS	S DECATUR HOME				559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 217	 failed to ensure 3 of #3) received annua findings are: A. Record review of nutritional review rewas done on 4/19/2 B. Record review of nutritional review rewas done on 4/19/2 C. Record review of nutritional review renutritional review renutritional review renutritional assessment home on 8/21/23. Interview on 6/5/24 disabilities profession have not had a reginago. The QIDP revent dietary orders that of group home. A follow-up survey was done on 4/19/2 B. Record review of nutritional review renutritional review renutritional review renutritional review of nutritional review renutritional review renutritional review of nutritional review renutritional review renutritional review renutritional review renutritional review renutritional review renutritional review renutritional review renutritional review renutritional review renutritional re	f 3 audit clients (#1, #2 and I nutritional evaluations. The h 6/4/24 of client #1's vealed the last assessment 3. h 6/4/24 of client #2's vealed the last assessment 3. h 6/5/24 of client #3's vealed an absence of a ent since his admission to the with the qualified intellectual onal (QIDP) revealed they stered dietician since a year ealed they were using the client #3 was on from his last was conducted on 9/3/24. h 9/3/24 of client #1's vealed the last assessment 3.	W 2	217			

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		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G239	B. WING				C 21/2024
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THOMAS	S DECATUR HOME				559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	nutritional evaluatio client #1, #2 or #3. still had no obtained A revisit was conduct Review on 11/21/20 intake log for Octob revealed he complet Review on 11/21/24 assessments revea 9/5/24 at 152 lbs. at lbs. Client #5 had a this period, with no PROGRAM IMPLEI CFR(s): 483.440(d) As soon as the inter formulated a client's each client must red treatment program interventions and se and frequency to su objectives identified plan.	with the QIDP confirmed no ons had been completed for The QIDP revealed the facility d a registered dietician. cted on 11/17/24. 024 of the client #5's daily ber and November, 2024 eted 100% of his meals. 4 of client #5's monthly nurse alled recorded weights on nd on 10/15/2024 at 127.86 24.14 lbs. weight loss during known reason. MENTATION	W 2				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(X3) DAT	E SURVEY
		DENTITION TON NONDER.	A. BUILD	ING	3		C
		34G239	B. WING	-		11/:	21/2024
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 7559 DECATUR DRIVE		
THOMAS	S S DECATUR HOME				FAYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI 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	ge 9	W 2	249	9		
	Observation on 11/2 surveyors entered t group home, which sensor in place, wa observation at 10:11 in his bedroom, with nap. An additional of #3 was in the kitcher with Staff B. Further observation during medication a client #3's right foot abrasion on the bot was in the healing p Interview on 11/21/2 had pain in the right running away. Clien walked barefooted to when he got lost, he 911. Interview on 11/21/2 #3 repeatedly re-inj toe because he was walking away from revealed the last kn aware of occurred of the home around 62 hour. Staff B reveal far as a local discou- was examined by E returned home by th Record review on 1 support plan (BSP)	21/24 at 10:00 am, the hrough the front door of the revealed the door alarm s turned off. A continued 0 am, client #3 was observed in the door closed, taking a observation at 11:15 am, client en helping to prepare lunch administration with Staff B, revealed he had a deep tom of his great big toe that ohase. 24 with client #3 revealed he t foot, because he hurt it when at #3 acknowledged he had to a gas station or store, and e asked for someone to call 24 with Staff B revealed client ured the wound on his right s often barefooted when the group home. Staff B bown incident that she was on 11/15/24 when client #3 left :30 am and was gone for an ed client #3 has traveled as unt store and gas station; and :MS services while AWOL and					

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		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G239	B. WING				C 21/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
THOMAS	S DECATUR HOME				559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	Continued From pa	ge 10	W 2	249			
	leave (AWOL) as so Client #3's objective rate of disruptive be episodes per month Further review reve Preventive Strategi When making threat talk about his feelin actively engage in so staff should interact aggression. If he be self-injurious behavi immediately block a behavior. A pillow o prevent injury. Whe staff is to verbally e	ats of self-harm, allow him to gs and ensure he does not self-harm or suicide. Only one t with him, during periods of egins to engage in viors (SIB), staff should and redirect to prevent this or towel could be used to en non-compliant, only one ngage him, no more than 2x in . Do not over prompt. Ask him					
	Attempted AWOL- all times, be sure to behavior. Let him k concerns and redire staff will be trained Manager or Qualifie Professional (QIDP implementation of p Record review on 1 reports revealed nu 2024 to elope from lay down in the road repeatedly on the g	Maintain line of sight on him at o avoid drawing attention to the now you will document his ect him to another activity. All by the Psychologist, Program ed Intellectual Disabilities P) QIDP in the appropriate orogram procedures. 1/21/24 of client #3's incident imerous attempts since April, the home, threaten suicide, d, and to bang his head round.					
		client #3 went outside of the aff K to follow him outside.					

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		34G239	B. WING	i			C 21/2024
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·	
THOMAS	S DECATUR HOME				7559 DECATUR DRIVE FAYETTEVILLE, NC 28303		
(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
W 249	Client #3 fell out in up when Staff K trie minutes, he got up home. Client #3 con attempts to leave th - On 8/1/24 at 10:15 threat to staff. - On 10/20/24 at 10 #3 attempted to lea stopped by staff. Cl head on the ground pillow to prevent fur redirected to his roo would "kill himself". him until he fell ask - On 11/14/24 at 7:3 elopement. - On 11/15/24 at 12 attempted elopeme he successfully elop - On 11/19/24 at 7:3 the facility. Interview on 11/21/2 (HM) revealed she elopements and ha week to notify him of Interview on 11/21/2 was aware of the pr received the incider incidents today. The receive messages f she contacted him of was already in bed; 11/15/24, "If he was something, when re assume he rememi	the street and refused to get and came back inside the ntinued to make repeated ne facility. 5 am, client #3 made a suicide 1:30 pm, Staff C revealed client ve the facility and was ient #3 then began to hit his l, prompting staff to use a ther harm. Client #3 was om, when he told staff he Staff stayed in the room with eep. 30 pm, client #3 attempted an 2:00 pm, client #3 an ont and later during third shift,	W 2	249			

Facility ID: 922748

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		34G239	B. WING			C 21/2024
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS	S DECATUR HOME			7559 DECATUR DRIVE FAYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	morning. Interview on 11/21/2	e to the home later that 24 with the QIDP Supervisor	W 24	9		
	supports for client # The QIDP Supervise wanted to appeal the was not in agreement been approved for for The QIDP Supervise	tried to get funding for 1:1 43 before but it was denied. or revealed the agency be decision, but the guardian ent, because client #3 had funding in another program. or acknowledged the guardian o coordinate discharging client home.				
	#5 had lost a lot of hospitalization. Staf	24 with Staff A revealed client weight recently before f A weighed client #5 on ded his weight at 141 lbs.				
W 318	client #5 was referr Assessment in Aug completed. The QIE overlooked following	ust, 2024 but it has not been DP acknowledged that he g up to get it scheduled.	W 31	8		
	The facility must en services requireme	sure that specific health care nts are met.				
		s not met as evidenced by: nsure that specific medical nts are met.				
		t met as evidenced by: The ure clients received annual				

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		AND HUMAN SERVICES			FORM	12/06/2024 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		34G239	B. WING	 		C 21/2024
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS	S S DECATUR HOME			559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 318	physical exams (W with nursing service needs (W331); non who work with clien licensed persons (V administered in cor orders (W368). The cumulative effer resulted in the facili statutorily mandate requirements. PHYSICIAN SERVI CFR(s): 483.460(a) The facility must pre examinations of ea- includes an evaluat This STANDARD is Based on record re facility failed to ensi and #3) received ar the doctor. The find A. Record review of chart revealed no e exam during a 12 n review revealed a no client #1 on 6/5/24 him with a Stage II buttocks and presc consult also revealed report (date unknow sore with medication medication was del Another medical co the qualified intelled	323);clients were provided es in accordance to their -licensed nursing personnel its are under the supervision of V347); all drugs are npliance with the physician's ect of these systemic practices ity's failure to provide d services of health care ICES 0(3)(i) ovide or obtain annual physical ch client that at a minimum ion of vision and hearing. s not met as evidenced by: eview and interviews, the ure 3 of 3 audit clients (#1, #2 n annual physical exam from	W a			

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		AND HUMAN SERVICES			FORM	: 12/06/2024 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		34G239	B. WING _			C 21/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS	S DECATUR HOME			7559 DECATUR DRIVE FAYETTEVILLE, NC 28303		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 323	response was order dermatologist. The to sacrum healing v height was recorder	utritionist referral. The doctor's rs for nutritionist and doctor added, "pressure ulcer well" and client #1's weight and	W 32	23		
	chart revealed no e exam during a 12 m C. Record review o	vidence of an annual physical nonths period. n 9/3/24 of client #3's medical vidence of an annual physical				
	doctor has not exar facility. The QIDP a referrals for the doc consultation forms.	with the QIDP revealed the mined any of the clients at the acknowledged he requests ctor and refills, on the medical The doctor reviews the forms signs and returns the form to				
	A follow-up visit was	s conducted on 11/21/24.				
		/24 of client #5's medical chart ce of an annual physical exam period.				
W 331	because client #5 w survey, he did not s		W 33	31		
	services in accorda This STANDARD is	ovide clients with nursing ince with their needs. s not met as evidenced by: eview and interviews, the				

Facility ID: 922748

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DEPARTMENT OF HEALTH AND H CENTERS FOR MEDICARE & MEI					FORM	12/06/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PR	OVIDER/SUPPLIER/CLIA INTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	34G239	B. WING				C 21/2024
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS S DECATUR HOME				559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331 Continued From page 15 facility failed to ensure 2 o #3) received the necessar services to prevent decline The findings are: A. Review on 6/4/24 of clie revealed on 10/28/23 a dis texture was first noticed or was determined to be an a new physician's orders rev protective cream to buttoc was no documentation on was still being treated or h 6/5/24, client #1 returned f appointment with a consul diagnosed him as having a on right buttocks. Interview on 6/5/24 with th disabilities professional (Q was no nurse working in th a contract nurse who came month. The QIDP acknow trained to contact him for r 6/1/24, he received a call f concerned about skin brea right buttocks and sent a p The QIDP revealed the bu a hole and he was worried developed a pressure ulce arrangements to get an ap to see the doctor. The QID nurse was notified on 6/5/2 pressure ulcer on buttocks B. During observations in t 5:45pm, client #1 wore a s right foot.	y ongoing nursing es in skin conditions. ent #1's nursing notes scoloration of unusual h his right buttocks that abscess. On 11/28/23, realed to apply a ks twice a day. There the chart the abscess ad worsened. On from a doctor's tant report that a stage II pressure ulcer e qualified intellectual (IDP) revealed there he home but there was e to the home every ledged, staff have been hursing concerns. On from staff who was akdown on client #1's photograph to the QIDP. ttock appeared to have that client #1 er and made immediate pointment for client #1 DP acknowledged the 24 of client #1's 5.	W 3	331			

Facility ID: 922748

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		AND HUMAN SERVICES					FORM	12/06/2024 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		34G239	B. WING	i				C 21/2024
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP C	DDE		
тнома	S S DECATUR HOME				7559 DECATUR DRIVE FAYETTEVILLE, NC 28303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
W 331	Record review on 6 client #3 was evalua- picking the skin on x-ray and ultrasoun with soft tissue injuid displaced soft tissue great toe. No fractue Client #3 was place to great toe. On 5/3 emergency room due exposed. Client #3 pressure ulcer on to be changed daily, w covered with bandar wear surgical shoet with his podiatrist in Interview on 6/5/24 would remove the b not always like to w acknowledged she shift and was clean that originated from A revealed she was had worsened to an Interview on 6/5/24 nurse was contractue time in the home. A follow-up visit was A. Record review o Monthly Assessment 6/24/24, 7/19/24 and completed an asses wound care service	 ¹/4/24 revealed on 5/1/24, ated for right foot pain, was the great toe and received an d. Client #3 was diagnosed ry and was noted to have e flap on the tip of his right re was detected from tests. ed on antibiotic for an infection 0/24, client #3 was sent to the ue to the fat layer on great toe was diagnosed with a right be. Client #3's dressing should with antibiotic ointment applied, the and he should continue to a Client #3 needs to follow-up the weeks. with Staff A revealed client #1 be surgical shoe. Staff A passed medications on day ing the wound on great toe a hang nail for client #3. Staff is not told client #3's toe injury in ulcer. with the QIDP revealed the ed and did not spend a lot of a sconducted on 9/3/24. n 9/3/24 of client #1 Nursing the revealed the following: On d 8/12/24, the nurse ssment without providing 	W	331				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C NAME OF PROVIDER OR SUPPLIER 34G239 B. WING 11/21/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/21/2024 THOMAS S DECATUR HOME STREET ADDRESS, CITY, STATE, ZIP CODE 7559 DECATUR DRIVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			AND HUMAN SERVICES				I	FORM	12/06/2024 APPROVED 0938-0391
346239 B. WING 11/21/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7390 DECATUR HOME 7390 DECATUR HOME 7390 DECATUR HOME 7390 DECATUR, NOTE 7400 DECATUR, NOTE 7400 DECATUR, NOTE 7400 DEFICIENCY MUST BE PRECEDED BY FULL 7400 DEFICIENCY	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	i í				X3) DATE COMI	E SURVEY PLETED
NME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STRE. ZIP CODE THOMAS 5 DECATUR HOME 7559 DECATUR PROFES (M)D SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PROCEEDED BY FUL RECOLUCTORY OR LSC IDENTIFYING INFORMATION) INPERVICE PROFENSURE DEPLAY OF CORRECTION RECOLUCTORY OR LSC IDENTIFYING INFORMATION) INPERVICE PROFENSURE DEPLAY OF CORRECTION RECOLUCTORY OR LSC IDENTIFYING INFORMATION) INPERVICE PROFENSURE DEPLAY OF CORRECTION RECOLUCTORY OR LSC IDENTIFYING INFORMATION) INPERVICE PROFENSURE DEPLAY OF CORRECTION RECOLUCIONS HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENTIFYING INFORMATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY W 331 Continued From page 17 chart revealed a medical consultation form from 6/5/24 where the doctor diagnosed him with a Stage II decubitious locer on right buttocks and prescribed occlusive dressing. The consult also revealed the nurse reviewed the report (date unknown) and instructed staff to treat sore with medication form completed by the qualified intellectual disabilities professional (QIDP) on 8/5/24 revealed a request for the doctor to make a nutritionist referental. The doctor's response was orders for nutritionist and dermatologist. The doctor added, "pressure ulcer to sacrum healing well". Interview on 9/3/24 with the QIDP revealed their contract nurse made monthy visits to the home. The QIDP revealed there were no indicated it was healed. B. Record review on 9/3/24 of client #3's Nursing Monthy Assessment revealed on 8/12/24, the nurse's note revealed foreire were no indicators of pain or wound care for client #3. Interview on 9/3/24 with the h			34G239	B. WING	i				
THOMAS S DECATUR HOME FAYETTEVILLE, NC 28303 [Mi]]D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIGT ERE PRECEDED BY FULL RECULATORY OR LSC DENTIFYING INFORMATION) D PROVIDER'S ALC CORRECTIVE ACTOR BROUD BRE (EACH DEFICIENCY WIGT RE PRECEDED BY FULL RECULATORY OR LSC DENTIFYING INFORMATION) D PROVIDER'S ALC CORRECTIVE ACTOR BROUD BRE (EACH DEFICIENCY) Observed W 331 Continued From page 17 chart revealed a medical consultation form from 6/5/24 where the doctor diagnosed him with a Stage II deculbitus uicer on right buttocks and prescribed occlusive dressing. The consult also revealed the nurse reviewed the report (date unknown) and instructed staff to treat sore with medication and bandage, after the medical consultation form completed by the qualified intellectual disabilities professional (QDP) on 8/5/24 revealed a request for the doctor to make a nutritionist referral. The doctor's response was orders for nutritionist and dermatologist. The doctor added, "pressure ulcer to sacrum healing well". Interview on 9/3/24 with the QIDP revealed their contract nurse made monthy visits to the home. The QIDP revealed the nurse was not providing Monthly Assessment revealed on 8/12/24, the nurse's note revealed on 8/12/24, the nurse's note revealed of 8/12/24, the nurse's note revealed for 8/32/24, the nurse's note revealed for 8/32/24, the nurse's note revealed their were no indicators of pain or wound care for client #3. Interview on 9/3/24 with the home manager revealed client #3 was na community outing for lunch and was unavailable to examine his toe	NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			-
Pričejik TAG (EACH OBERICITIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREE/X TAG (EACH OBERICITIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Conditioned From Not State Sta	THOMAS	S DECATUR HOME							
 chart revealed a medical consultation form from 6/5/24 where the doctor diagnosed him with a Stage II decubitus ulcer on right buttocks and prescribed occlusive dressing. The consult also revealed the nurse reviewed the report (date unknown) and instructed staff to treat sore with medication and bandage, after the medication was delivered from pharmacy. Another medical consultation form completed by the qualified intellectual disabilities professional (QIDP) on 8/5/24 revealed a request for the doctor to make a nutritionist referral. The doctor's response was orders for nutritionist and dermatologist. The doctor's dependence was orders for nutritionist and dermatologist. The doctor added, "pressure ulcer to sacrum healing well". Interview on 9/3/24 with the home manager revealed client #1's pressure ulcer healed. Interview on 9/3/24 with the QIDP revealed their contract nurse made monthly visits to the home. The QIDP revealed the nurse was not providing wound care and there were no nursing notes on the measurements of client #1's snursing Monthly Assessment revealed to 8/12/24, the nurse's note revealed there were no indicators of pain or wound care for client #3. Interview on 9/3/24 with the home manager revealed client #3 was on a community outing for lunch and was unavailable to examine his toe 	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD B	E ATE	COMPLETION
Interview on 9/3/24 with the QIDP revealed client #3 was still getting wound care from the direct	W 331	chart revealed a me 6/5/24 where the do Stage II decubitus of prescribed occlusive revealed the nurse unknown) and instr- medication and bar was delivered from consultation form co- intellectual disabiliti 8/5/24 revealed a re- a nutritionist referra orders for nutritionist doctor added, "pres- well". Interview on 9/3/24 revealed client #1's Interview on 9/3/24 contract nurse mad The QIDP revealed wound care and the the measurements and progress notes B. Record review of Monthly Assessmen nurse made a mont nurse's note revealed pain or wound care Interview on 9/3/24 revealed client #3 w lunch and was unaw with the pressure ut Interview on 9/3/24	edical consultation form from botor diagnosed him with a ulcer on right buttocks and e dressing. The consult also reviewed the report (date ucted staff to treat sore with hadage, after the medication pharmacy. Another medical ompleted by the qualified es professional (QIDP) on equest for the doctor to make al. The doctor's response was st and dermatologist. The ssure ulcer to sacrum healing with the home manager pressure ulcer healed. with the QIDP revealed their le monthly visits to the home. the nurse was not providing ere were no nursing notes on of client #1's pressure ulcer that indicated it was healed. n 9/3/24 of client #3's Nursing nt revealed on 8/12/24, the thly visit to the home. The ed there were no indicators of for client #3. with the home manager vas on a community outing for vailable to examine his toe lcer. with the QIDP revealed client	W	331				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G239	B. WING				C 21/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THOMAS	S DECATUR HOME				559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 331	Continued From pa	ge 18	W 3	331			
	care professionals a care documentation	and he did not have any skin n for the ulcer.					
	A follow-up visit was	s conducted on 11/21/24.					
	intake log for Octob	/2024 of the client #5's daily per and November, 2024 eted 100% of his meals.					
	assessments revea 9/5/24 at 152 lbs. a	of client #5's monthly nurse led recorded weights on nd on 10/15/2024 at 127.86 24.14 lbs. weight loss during known reason.					
	she completed her 10/15/24 and did no	24 with the nurse revealed that monthly assessment on ot notice the 24.14 lb. weight eights from the previous					
	Sheet," revealed he between 10/1/24 to 9 bowel movements 2024. The data flow one hard bowel mov	of client #5's "Daily Flow had only 4 bowel movements 10/15/24. There was a total of is in the month of October, y sheet revealed client #5 had vement on 10/23/24 but no was documented prior to a copy on 10/25/24.					
	assessments revea on 10/15/24, detect	of client #5's monthly nursing led the nurse examined him ing no problems or concerns ds, when stethoscope applied					
	report dated 10/23/2	of client #5's Gastrostomy 2024 noted client #5's diopathic constipation,					

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		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT COM	E SURVEY PLETED
		34G239	B. WING				C 21/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
				7	7559 DECATUR DRIVE		
THOMAS	S DECATUR HOME				AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 331	Continued From pa	ge 19	W 3	331			
	abdominal pain, un	intentional weight loss, and a be screened for chronic					
	was not aware of cl movements in Octo period. The nurse r complete in-depth a referrals for the clie meeting, or ask the concerns regarding acknowledged she	24 with the nurse revealed she ient #5 experiencing no bowel ober, 2024 for a prolonged evealed she does not assessments, make health onts, attend treatment team QIDP questions about the clients' health. The nurse was not contacted when client alized 11/6/24 to 11/7/24 due ion.					
	revealed she is sup Flow Sheet" every t reviewing the sheet prompting her to inf to provide documer Interview on 11/21/2 client #5 was scheo 10/25/24, of which w impaction. The QID the colonoscopy ins recalled sharing the did not know if they QIDP further stated was unsuccessful a not eliminating all o appointment. He ac be hospitalized on 2 bowel obstruction.	louse Manager on 11/21/24 posed to review the "Daily three days. She admitted to c, noticing client #5's data, form the QIDP, but was unable ntation of their conversation. 24 with the QIDP revealed that duled for a colonoscopy on was unsuccessful due to fecal P revealed he had received structions in advance and em with direct care staff, but he followed the directions. The the colonoscopy procedure and canceled due to client #5 f his stool, prior to the cknowledged client #5 had to 11/6/24 to 11/7/24 due to a					
	facility failed to ensu	veiw and interviews, the ure 3 of 5 clients (#1, #3, and essary ongoing nursing					

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		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		34G239	B. WING				C 21/2024
NAME OF F	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS	S DECATUR HOME				7559 DECATUR DRIVE FAYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	Continued From par services to prevent Review of client #5' nurse 's monthly as 8/12/24, 151lbs, 9/5 127.86lbs, a weight Review of the Octob revealed staff recor- during the month, an nurse's assessmen movement from 10/7 Review of the diagr Gastroenterology and revealed that client chronic, idiopathic of unintentional weigh chronic Neoplasia. Interview with the har revealed that it was the data flow sheet that she recognized consistent bowel ma QIDP. She advised of her report to the #5 attended a Gast	ge 20 decline. Finding are: s weight recorded on the ssessment were as follows: 5/24, 152lbs and on 10/15/24, c loss of 24.14 lbs. in 39 days. ber 24 Daily Flow Sheet ded 9 bowel movements and 10/15/2024 the date of the t he had only two bowel	W (DEFICIENCY)		
	The nurse further re communicated any infrequency of bowe	g on the 10/15/24 assessment. evealed that staff did not problems with client # 5 's el movements. She admitted garding his health status and					

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DEPARTMENT OF HEALTH AND HUMAN CENTERS FOR MEDICARE & MEDICAID				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/S	SUPPLIER/CLIA (X2) MI	ULTIPLE CC	DNSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
34	G239 B. WIN	IG			C 21/2024
NAME OF PROVIDER OR SUPPLIER		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS S DECATUR HOME			DECATUR DRIVE ETTEVILLE, NC 28303		
(X4) ID SUMMARY STATEMENT OF DEFIC PREFIX (EACH DEFICIENCY MUST BE PRECE TAG REGULATORY OR LSC IDENTIFYING II	DED BY FULL PRE	FIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
 W 331 Continued From page 21 no concerns were reported. She were member the staff's name or destadvised that she does not compatassessment information, and this she also does not attend treatment meetings, or request information in health status of each client the horadvised if there is a problem, her for staff including the house manato to tell her, and they should contact care physician. She further advised not make referrals. She only provide management training and complet assessments. She further revealed also unaware that client #5 was his 11/7/24 for a bowel obstruction. Interview with the QIDP revealed established means of communication of concerns amongst the nurse, how and QIDP, and he further revealed weight loss and bowel concerns vident concerns with the supervision of licensed This STANDARD is not met as e Based on observation, record revinterview, the facility failed to ensute technicians were supervised by a in order to perform wound care trapressure ulcers for 2 of 3 audit cli #3). The findings are: 	was unable to scription. She re previous include weights, int team regarding the ome. She expectation is ager and QIDP of the primary ed that she does ides medication ete monthly ed that she was ospitalized on there is no ating health ise manager d that client #5's vas not W who work with must do so persons. videnced by: view and ure medication licensed nurse eatments for ients (#1 and	' 331 ' 347			

If continuation sheet Page 22 of 28

		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		34G239	B. WING				C 21/2024
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS	S S DECATUR HOME				559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 347	consultation form o diagnosed with a Si buttocks and presc consult also reveals report (date unknow sore with medicatio medication was del were no notes of ar the skin condition o months period. The the pressure ulcer of healed. Record review on 9 nursing assessmen 8/12/24; revealed th wound care service Interview on 9/3/24 revealed client #1's direct care professi treatment. Interview on 9/3/24 contract nurse mad The QIDP revealed wound care and the the measurements and progress notes B. Record review of nursing assessment were no indicators of provided by the nur-	n 6/5/24, client #1 was tage II decubitus ulcer on right ribed occlusive dressing. The ed the nurse reviewed the wn) and instructed staff to treat on and bandage, after the livered from pharmacy. There ny treatments prescribed and of the pressure ulcer over a 3 e record lacked documentation on the right buttock was 0/3/24 of client #1's monthly nts, on 6/24/24, 7/19/24 and ne nurse did not perform es for client #1 during the visits. with the home manager pressure ulcer healed, and onals applied medications for with the QIDP revealed their le monthly visits to the home. I the nurse was not providing ere were no nursing notes on of client #1's pressure ulcer a that indicated it was healed. n 9/3/24 of client #3's monthly nt on 8/12/24, revealed there of pain or wound care rse. with the home manager eceived wound care from	W 3	347			

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		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COM	E SURVEY PLETED
		34G239	B. WING				C 21/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THOMAS	S DECATUR HOME				559 DECATUR DRIVE		
				<u>г</u> л	AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 347	Continued From pa	ide 23	w a	47			
	•	with the QIDP revealed client		' די			
		wound care from the direct					
		and he did not have any skin					
	care documentation	ו for the ulcer.					
	A follow-up visit was	s conducted on 11/21/24.					
	Staff B entered the #3, unlocked the m medication cart. Sta	21/24 at 2:00 pm, revealed medication room with client edication closet to remove the aff B used a key to unlock the premove 1 capsule of					
	Gabapentin 300mg other staff in the roo	for client #3. There was no om that counted the controlled or after Staff B dispensed the					
	medication adminis #3 revealed the foll Clonazepam 1 mg, agitation. Client #3	1/21/24 of the November 2024 stration record (MAR) for client owing: a prescription for to take every 12 hours for s was diagnosed with y, Bipolar Disorder, Post					
	Disorder. The back	bisorder and Schizoaffective of the MAR documented					
	11/7/24. There wer	ut of stock between 11/1/24 to re two blister packs, containing f Clonazepam that started on					
	11/11/24. Out of the (total 56 pills) only §	e two packs of medications, 9 pills were missing. There					
	pack, which date or	tion on the back of the blister staff administered the pills to					
	back of the MAR, th	staff had documented on the ne Clonazepam was					
	times: 11/13/24 at 8	ent #3 on these dates and 3:00 am/pm, 11/16/24 at 8:00					
		0 am, 11/19/24 at 8:00					
	8:00 am.	t 8:00am/pm and 11/21/24 at					

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		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ·			(X3) DATE SURVEY COMPLETED		
		34G239	B. WING			C 11/21/2024	
NAME OF	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS	S S DECATUR HOME				7559 DECATUR DRIVE FAYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 347	Continued From pa	ge 24	w a	347			
	November, 2024 in elopements on 11/1 12:00 pm an attemp client #3 successfu as on 11/19/24 at 7 Interview on 11/21/2 (HM) revealed they with the mental hear filling the prescription there has been gap The HM further ack instructed by the QI sign the blister pack revealed she normative week to make sure medications. The H determine which state medication, she wo footage of the medic D. Record review on November, 2024 M blood glucose num diabetic guidance in recognize hypergly symptoms. There w constituted elevated 11/6/24 at 7:00 am, on 11/7/24 at 7:30 at at 7:00 am, it was 2 Record review on 1 Assessment report #1 had no current is	24 with the Home Manager have had ongoing problems lith agency and the pharmacy ons in a timely manner and is in medications coverage. mowledged, she had been IDP that they did not have to and date them. The HM ally reviewed the MARs every clients received their IM acknowledged in order to aff did not give client #3 his uld need to review the video to aff did not give client #1's AR revealed staff recorded his bers daily on a log. There was in the MAR binder on how to cemia and low blood sugar vas no guidance on what d blood glucose levels. On the blood glucose was 270, am, it was 359 and on 11/8/24 246. 1/21/24 of the Nurse Monthly from 10/15/24 revealed client					

		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G239	B. WING				C 21/2024
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS	S DECATUR HOME				559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 347	sometimes client #X the morning and it i provided with a lot of acknowledged staff glucose later, and a have any follow-up elevated. Interview on 11/21/2 that he reviews the Review of client #5' nurse's monthly ass 8/12/24, 151 lbs., 9 10/15/24, 127.86 lb in 39 days. Review of the Octoor revealed staff recorn during the month, a nurse's assessment movement from 10/2 Review of the diagorn Gastroenterology a revealed that client chronic, idiopathic of unintentional weigh chronic Neoplasia. Interview on 11/21/2 her 10/15/24 month documented there of advised that she us for normal bowels, recorded her finding The nurse further re- communicate any p	 ³ had high blood glucose in mproved afterwards if of water. The HM ⁵ should recheck the blood acknowledged the log did not readings recorded after it was ²⁴ the QIDP acknowledged MARs along with the HM. ⁵ s weight recorded on the sessment were as follows: /5/24, 152 lbs. and on s., a weight loss of 24.14 lbs. ⁶ ber 24 Daily Flow Sheet ded 9 bowel movements and 10/15/2024 the date of the the had only two bowel 	W 3	347			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 34G239 B. WING 11/21/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/21/2024 THOMAS S DECATUR HOME STREET ADDRESS, CITY, STATE, ZIP CODE FAYETTEVILLE, NC 28303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391			
34G239 B. WING 11/21/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 759 DECATUR HOME 759 DECATUR DRIVE (M) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID ID PROVIDERS OR SHAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID ID CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 26 to asking a staff regarding his health status and no concerns were reported. She was unable to remember the staffs name or description. She advised that she does not attend treatment team meetings, or request information, and this include weights, she also does not attend treatment team meetings, or request information regarding the health status of each client the home. She advised if there is a problem, her expectation is for staff including the house manager and QIDP to tell her, and they should contact the primary care physician. She further revealed that she does not make referrals. She only provides medication management training and complete monthly assessments. She further revealed that she was also unaware that client #5 was hospitalized on 11/7/24 for a bowel obstruction. W 368 W 388 DRUG ADMINISTRATION CFR(s): 483.460(k)(1) W 368 W 368 ID The system for drug administration must assure that all drugs are admininterview, the facility W 368	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` '		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED					
THOMAS S DECATUR HOME 7559 DECATUR DRIVE FAVETTEVILE, NC 28303 PM: ID TREENX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREENX PROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENT TAG ID PREENX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENT TAG COMMENT TAG ID PREENX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENT TAG COMMENT TAG <td< td=""><td></td><td></td><td>34G239</td><td>B. WING_</td><td></td><td></td><td></td><td></td></td<>			34G239	B. WING_							
FAYETTEVILLE, NC 28303 (MI ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ICACH CORRECTION SPLAN OF CORRECTION (ECACH CORRECTIVE ACTION SHOULD BE (ECACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (MICA OWNET TAG W 347 Continued From page 26 to asking a staff regarding his health status and no concerns were reported. She was unable to remember the staff's name or description. She advised that she does not compare previous assessment information regarding the health status of each client the home. She advised if there is a problem, her expectation is for staff including the house manager and QIDP to tell her, and they should contact the primary care physician. She further advised that she does not make referrals. She only provides medication management training and complete monthly assessments. She further revealed that she was also unaware that client #5 was hospitalized on 11/17/24 for a bowle obstruction. W 368 W 368 DRUG ADMINISTRATION CFR(s): 483.460(k)(1) W 368 W 368 DRUG ADMINISTRATION CFR(s): 483.460(k)(1) W 368	NAME OF F	ROVIDER OR SUPPLIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE					
Preferix TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH DERICENCY ANOLED BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 347 Continued From page 26 to asking a staff regarding his health status and no concerns were reported. She was unable to remember the staffs name or description. She advised that she does not compare previous assessment information, and this include weights, she also does not attend treatment team meetings, or request information regarding the health status of each client the home. She advised if there is a problem, her expectation is for staff including the house manager and QIDP to tell her, and they should contact the primary care physician. She further revealed that she does not make referrals. She only provides medication management training and complete monthly assessments. She further revealed that she was also unaware that client #5 was hospitalized on 11/7/24 for a bowel obstruction. W 368 W 368 DRUG ADMINISTRATION CFR(s): 483.460(k)(1) W 368 The system for drug administration must assure that all drugs are administration the facility W 368	THOMAS	S DECATUR HOME									
 to asking a staff regarding his health status and no concerns were reported. She was unable to remember the staff's name or description. She advised that she does not compare previous assessment information, and this include weights, she also does not attend treatment team meetings, or request information regarding the health status of each client the home. She advised if there is a problem, her expectation is for staff including the house manager and QIDP to tell her, and they should contact the primary care physician. She further advised that she does not make referrals. She only provides medication management training and complete monthly assessments. She further revealed that she was also unaware that client #5 was hospitalized on 11/7/24 for a bowel obstruction. Interview with the QIDP revealed there is no established means of communicating health concerns amongst the nurse, house manager and QIDP, and he further revealed that client #5's weight loss and bowel concerns was not communicated to the nurse. W 368 DRUG ADMINISTRATION CFR(s): 483.460(k)(1) W assest more drag administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and interview, the facility 	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION			
ordered for 1 of 3 audit clients (#3). The finding is: Record review on 11/21/24 of the November 2024 medication administration record (MAR) for client		to asking a staff reg no concerns were r remember the staff advised that she do assessment inform she also does not a meetings, or reques health status of eac advised if there is a for staff including th to tell her, and they care physician. She not make referrals. management trainin assessments. She also unaware that of 11/7/24 for a bowel Interview with the C established means concerns amongst and QIDP, and he f weight loss and boy communicated to th DRUG ADMINISTR CFR(s): 483.460(k) The system for drug that all drugs are ac the physician's orde This STANDARD is Based on record re did not ensure med ordered for 1 of 3 a is: Record review on 1	garding his health status and eported. She was unable to 's name or description. She bes not compare previous ation, and this include weights, attend treatment team st information regarding the ch client the home. She a problem, her expectation is he house manager and QIDP should contact the primary e further advised that she does She only provides medication ng and complete monthly further revealed that she was client #5 was hospitalized on obstruction. QIDP revealed there is no of communicating health the nurse, house manager further revealed that client #5's wel concerns was not he nurse. RATION (1) g administration must assure dministered in compliance with ers. s not met as evidenced by: eview and interview, the facility lications were given as udit clients (#3). The finding 1/21/24 of the November 2024								

		AND HUMAN SERVICES				FORM	12/06/2024 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G239	B. WING				C 21/2024
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
THOMAS	S S DECATUR HOME				559 DECATUR DRIVE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 368	#3 revealed the foll Clonazepam 1 mg, agitation. Client #3' intellectual disability Traumatic Stress D Disorder. The back Clonazepam was o 11/7/24. There wer a 28 days' supply o 11/11/24. Out of the (total 56 pills) only 9 was no documentar pack, which date or client #3. Several s back of the MAR, th administered to clie times: 11/13/24 at 8:00 am/pm, 11/20/24 at 8:00 am. Interview on 11/21/2 (HM) revealed they with the mental hea filling the prescription there has been gap The HM further ack instructed by the QU sign the blister pach revealed she normar week to make sure medications. The H determine which sta	owing: a prescription for to take every 12 hours for s was diagnosed with y, Bipolar Disorder, Post Disorder and Schizoaffective of the MAR documented but of stock between 11/1/24 to re two blister packs, containing of Clonazepam that started on the two packs of medications, 9 pills were missing. There tion on the back of the blister r staff administered the pills to staff had documented on the he Clonazepam was ent #3 on these dates and 3:00 am/pm, 11/16/24 at 8:00 0 am, 11/19/24 at 8:00 t 8:00am/pm and 11/21/24 at 24 with the Home Manager r have had ongoing problems alth agency and the pharmacy ons in a timely manner and bs in medications coverage. showledged, she had been IDP that they did not have to ks and date them. The HM ally reviewed the MARs every or clients received their IM acknowledged in order to aff did not give client #3 his build need to review the video	W 3	68			

Facility ID: 922748

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