

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

PRINTED: 12/12/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/09/2024
NAME OF PROVIDER OR SUPPLIER WILSON SMITH COTTAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 185 MARTINDALE RD WINSTON SALEM, NC 27107		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS	W 000			
W 331	<p>NURSING SERVICES CFR(s): 483.460(c)</p> <p>The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to provide nursing services in accordance with the needs of 1 of 2 sampled clients (#1). The finding is:</p> <p>Review of documents on 12/9/24 revealed an incident report for client #1 dated 9/26/24 that revealed the client to be sent to the ED due to staff noticing that the client was not walking like his usual self. Continued review of documents revealed an after-visit summary regarding ED visit on 9/26/24 with discharge instructions for client #1 to use Tylenol and /or Ibuprofen for pain, ice, and compression, and to follow-up with Ortho as needed. Further review of documents revealed an incident report dated 9/29/24 to reveal client #1 to be sent to the ED due to swollen left knee and the client was admitted into the hospital.</p> <p>Interview on 12/9/24 with the qualified intellectual disabilities professional (QIDP) and home manager (HM) revealed that client #1 was sent to the hospital on 9/26/24 and 9/29/24 due to swollen left knee; however, no discharge paperwork for 9/29/24. Continued interview with the QIDP revealed that there is no documentation</p>	W 331			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 331	<p>Continued From page 1</p> <p>providing follow-up care for client #1 regarding 9/26/24 discharge instructions.</p> <p>Interview on 12/9/24 with the facility nurse revealed that client #1 was sent to the ED on 9/26/24. Facility nurse was not aware of the 9/26/24 hospital visit and later stated she had an Ortho consult for 9/26/24; however, the client was sent to ED by the HM. The manager and the QP receive the medical consultations and schedule all medical appointments. Facility nurse advised staff to take client back to the ED on 9/29/24 at 10:11 am due to the left knee being excessively swollen and nurse did not receive any further information from the hospital. It is also noted that the client did not return to the group home following his release from the hospital and has been discharged from the group home on 10/2/24.</p>	W 331			