PRINTED: 01/08/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		34G103	B. WING				₹	
NAME OF I	200//050 00 01/001/50	340103	D. W.110		20005	01/0	03/2025	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE			
MY PLAC	CE			1050 HOGAN STREET				
	_			FAYETTEVILLE, NC 28301				
(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 C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPR	BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMEN	тѕ	w o	00				
{W 195}	deficiencies cited d 11/19/24. Some of corrected; however of compliance. ACTIVE TREATME CFR(s): 483.440 The facility must er treatment services This CONDITION The team failed to: initial Physical Ther examination (W210 psychological evaluation)	ucted on 1/3/25 for all previous uring the recertification on the deficiencies have been the condition still remains out ENT SERVICES Insure that specific active requirements are met. is not met as evidenced by: ensure client received an appropriate and action (W214); ensure client physical (W216); ensure	{W 19	95}				
	ensure client receiv (W218); ensure clie speech/language e client received an a ensure clients Indiv completed (W226); developed necessa clients (W227); ens	al Nutritional evaluation (217); yed an sensorimotor evaluation ent received an initial valuation (W220); ensure auditory examination (W221); yidual Program Plan (IPP) were gensure objectives are any to meet the needs of the sure that client received a						
	includes aggressive a program of special treatment directed behaviors necessal as much self-determination (W249); eclient inappropriate an integral part of the special post of the second control of	reatment program, which e, consistent implementation of alized and generic training and towards the acquisition of the ry for the client to function with mination and independence as nsure drugs used to manage behaviors were used only as heir Individual Program Plan						
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		34G103	B. WING			R (02/2025	
NAME OF F	PROVIDER OR SUPPLIER	040100		STREET ADDRESS, CITY, STATE, ZIP 1050 HOGAN STREET FAYETTEVILLE, NC 28301	•	/03/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
{W 195}	examination (W351 The cumulative efferesulted in the facilistatutorily mandated the client. A follow up visit was Observations, interduring the follow up Condition of of Active Compliance. ACTIVE TREATME CFR(s): 483.440(a) Each client must retreatment program, consistent implements specialized and genservices and related subpart, that is directly in the client to function the client to function determination and interest (ii) The prevention or loss of current opense.	e client received dental). ect of these systemic practices ty's failure to provide d active treatment services to s conducted on 1/3/25. views and record verification e visit on 1/3/25 determined the ve Treatment to still be out of NT (1) ceive a continuous active which includes aggressive, entation of a program of neric training, treatment, health d services described in this cted toward: of the behaviors necessary for					
	specialized treatme audit client (#4) in the	aggressive implementation of nt to 1 of 1 newly admitted ne areas of dining, sure and choice making. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED R			
		34G103	B. WING				≺ 03/2025
MY PLAC	PROVIDER OR SUPPLIER			105	EET ADDRESS, CITY, STATE, ZIP CODE 0 HOGAN STREET 'ETTEVILLE, NC 28301	1 017	00/2020
(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 196}	A. Cross reference ensure initial Physic prepared and visual conducted within 30 newly admitted aud. B. Cross reference ensure initial psych prepared within 30 newly admitted aud. C. Cross reference ensure annual physic conducted within 30 newly admitted aud. D. Cross reference ensure initial Nutriti within 30 days of acadmitted audit cliented. E. Cross reference ensure sensorimoto within 30 days of acadmitted audit cliented.	e W210. The facility failed to cal Therapy evaluation was I examination was was 0 days of admission for 1 of 1 it client (#4). e W214. The facility failed to cological evaluation was days of admission for 1 of 1 it client (#4). e W216. The facility failed to cical examination was 0 days of admission for 1 of 1 it client (#4). e W217. The facility failed to conal evaluation was prepared dmission for 1 of 1 newly t (#4).	{W 15	96}	DEFICIENCY)		
	ensure initial speed	h/language evaluation was days of admission for 1 of 1					
	ensure an auditory	e W221. The facility failed to examination was conducted dmission for 1 of 1 newly t (#4).					
		W226. The facility failed to all Program Plan (IPP) was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` '	l ` ′	TIPLE CONSTRUCTION NG	()	(X3) DATE SURVEY COMPLETED	
		34G103	B. WING			R 01/03/2025	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1050 HOGAN STREET FAYETTEVILLE, NC 28301	CODE	01/03/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		N SHOULD B E APPROPRIA		
{W 196}	I. Cross reference ensure objectives v admission for 1 of (#4). J. Cross reference ensure implementa strategies and progprepared within 30 newly admitted aud K. Cross reference ensure drugs used inappropriate behavintegral part of the	days of admission for 1 of 1 lit client (#4). W227. The facility failed to was prepared within 30 days of 1 newly admitted audit clients W249. The facility failed to tion of effective behavioral tram implementation was days of admission for 1 of 1 lit clients (#4). W312. The facility failed to to manage clients viors were used only as an Individual Program Plan was days of admission for 1 of 1	{W 19	96}			
	ensure a dental exa	` ,					
{W 210}	revealed the condit		{W 21	10}			
	assessments or rea	r admission, the m must perform accurate assessments as needed to liminary evaluation conducted					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G103	B. WING				R 1202E
NAME OF F	PROVIDER OR SUPPLIER	040.00		STR	REET ADDRESS, CITY, STATE, ZIP CODE 0 HOGAN STREET YETTEVILLE, NC 28301	1 017	03/2025
(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 210}	Based on record refailed to obtain an in	ge 4 s not met as evidenced by: eview and interview, the facility nitial visual examination for 1 audit clients (#4). The finding	{W 2 ²	10}			
	he was admitted to Further review clien	of client #4's record revealed the facility on 2/27/24. It #4 had a visual examination was uncooperative.					
	Intellectual Disabilit	on 11/18/24, the Qualified ies Professional (QIDP). The #4's visual examination has ed.					
	A follow up was cor	nducted on 1/3/25.					
		f client #4's record revealed al examination had been					
{W 216}	Intellectual Disabilit		{W 2 ⁻	16}			
	include physical dev This STANDARD is Based on record re facility failed to ensi clients (#4) had a N	e functional assessment must velopment and health. s not met as evidenced by: eview and interviews the ure 1 of 1 newly admitted lursing evaluation done within on. The findings are:					
	Review on 11/18/24	of client #4's record revealed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G103	B. WING				R
NAME OF P	PROVIDER OR SUPPLIER	040100		STF 105	REET ADDRESS, CITY, STATE, ZIP CODE 50 HOGAN STREET YETTEVILLE, NC 28301	<u> U170</u>	03/2025
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 216}	Further review revenursing evaluation. During an interview Intellectual Disabilit confirmed client #4 evaluation. A follow up visit was Review on the Plan revealed client #4 devaluation. During an interview confirmed client #4 evaluation. INDIVIDUAL PROGUETR(s): 483.440(c) The individual progrobjectives necessar as identified by the required by paragratis STANDARD is Based on observat reviews, the facility admitted audit clien Plans (IPP) include address the clients During observations 19/24, client #4 was living room, leaning some type of plastices.	the facility on 2/27/24. aled client #4 did not have a on 11/18/24, the Qualified ies Professional (QIDP) did not have a Nursing s conducted on 1/3/25. of Correction on 1/3/25 oes not have a Nursing on 1/3/25, the QIDP does not have a Nursing GRAM PLAN	{W 22				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		34G103	B. WING				R 03/2025
MY PLA	PROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 050 HOGAN STREET AYETTEVILLE, NC 28301	1 017	03/2023
(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 227}	training or objective 11/19/24 from 6:56a observed stacking a on and off during the Review revealed clihome on 2/27/24. I client #4's IPP date have any formal training an interview Manager (HM) reveany objectives or go revealed client #4 grown anything. The HM skills client #4 proceduring an interview Intellectual Disability revealed he has no for client #4. Further	es. Further observations on am thru 8:13am, client #4 was and re-staking plastic blocks, at time. The statement of the further review on 11/18/24 of d 7/11/24 revealed he did not sining or goals. The on 11/18/24, the Home ealed client #4 does not have bals. Further interview loes not like to participate in stated she is not sure what	{W 22	27}			
	During morning obs 1/3/25 from 7am - 7 observed sitting in a	s conducted on 1/3/25. servations in the home on 7:45am, client #4 was a chair. Further observations did staff interact with client					
	revealed client #4 c goals. During an interview	f the Plan of Correction loes not have any formal on 1/3/25, the QIDP revealed ented any new goals for client					

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MY PLACE	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1050 HOGAN STREET FAYETTEVILLE, NC 28301	1 017	00/2020
(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 249}	As soon as the interpretation formulated a client's each client must retreatment program interventions and seand frequency to su		{W 24	49}			
	Based on observatinterviews, the facil interactions supportor 1 of 1 newly adrespecific to commun vocational skills, seliving, implementati	is not met as evidenced by: cions, record reviews and staff ity failed to ensure a pattern of ted the active treatment plans nitted audit clients (#4), cication, independent living, nsory stimulation, community on of effective behavioral ram implementation. The					
	19/24, client #4 was living room, leaning some type of plastic a wheelchair that be home. Client #4 dictraining or objective 11/19/24 from 6:56a	s during the survey on 11/18 - s observed either sitting in the by a bookcase and pulling at the bottom of it or touching elonged to another client in the d not participate in any formal ss. Further observations on am thru 8:13am, client #4 was and re-staking plastic blocks, at time.					
	facility on 2/27/24. #4's IPP dated 7/11	ent #4 was admitted to the Further review on of client /24 revealed he has n. Further review revealed he					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	34G103	B. WING				R 02/2025	
	040100		ST 10	50 HOGAN STREET	<u> U170</u>	03/2025	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
did not have any for During an interview Intellectual Disabilit revealed a local net client #4 with Sever A follow up visit was During morning obs 1/3/25 from 7am - 7 observed sitting in a revealed at no time #4. Review on 1/3/25 or revealed client #4 digoals. During an interview he has not implement #4. PROGRAM MONIT CFR(s): 483.440(f)(f)(f)(f) At least annually, the must be revised, as process set forth in This STANDARD is Based on record refacility failed to upday Plans (IPP) annually and #3). The finding A. Review on 11/18	on 11/19/24, the Qualified les Professional (QIDP) prological clinic had diagnosed e Intellectual Disability. Is conducted on 1/3/25. Intervations in the home on 1/3/25, the QIDP revealed and staff interact with client on 1/3/25, the QIDP revealed on 1/3/25, the Q						
	PROVIDER OR SUPPLIER SUMMARY STAY (EACH DEFICIENCY REGULATORY OR LS) Continued From partial did not have any for During an interview Intellectual Disability revealed a local net client #4 with Severy A follow up visit was During morning observed sitting in a revealed at no time #4. Review on 1/3/25 of revealed client #4 digoals. During an interview he has not implement #4. PROGRAM MONIT CFR(s): 483.440(f)() At least annually, the must be revised, as process set forth in This STANDARD is Based on record refacility failed to upday plans (IPP) annually and #3). The finding A. Review on 11/18 revealed an IPP day review of client #2's	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 did not have any formal training or goals. During an interview on 11/19/24, the Qualified Intellectual Disabilities Professional (QIDP) revealed a local neurological clinic had diagnosed client #4 with Severe Intellectual Disability. A follow up visit was conducted on 1/3/25. During morning observations in the home on 1/3/25 from 7am - 7:45am, client #4 was observed sitting in a chair. Further observations revealed at no time did staff interact with client #4. Review on 1/3/25 of the Plan of Correction revealed client #4 does not have any formal goals. During an interview on 1/3/25, the QIDP revealed he has not implemented any new goals for client #4. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to update the Individual Program Plans (IPP) annually for 2 of 4 audit clients (#2 and #3). The findings are: A. Review on 11/18/24 of client #2's record revealed there was no	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 did not have any formal training or goals. During an interview on 11/19/24, the Qualified Intellectual Disabilities Professional (QIDP) revealed a local neurological clinic had diagnosed client #4 with Severe Intellectual Disability. A follow up visit was conducted on 1/3/25. During morning observations in the home on 1/3/25 from 7am - 7:45am, client #4 was observed sitting in a chair. Further observations revealed at no time did staff interact with client #4. Review on 1/3/25 of the Plan of Correction revealed client #4 does not have any formal goals. 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WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 did not have any formal training or goals. During an interview on 11/19/24, the Qualified Intellectual Disabilities Professional (OIDP) revealed a local neurological clinic had diagnosed client #4 with Severe Intellectual Disability. A follow up visit was conducted on 1/3/25. During morning observations in the home on 1/3/25 from 7am - 7-45am, client #4 was observed stiting in a chair. Further observations revealed client #4 does not have any formal goals. During an interview on 1/3/25, the QIDP revealed he has not implemented any new goals for client #4. Review on 1/3/25 of the Plan of Correction revealed client #4 does not have any formal goals. During an interview on 1/3/25, the QIDP revealed he has not implemented any new goals for client #4. Review on 1/3/25 of the plan of Correction revealed client #4 does not have any formal goals. At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by. Based on record reviews and interviews, the facility failed to update the Individual Program Plans (IPP) annually for 2 of 4 audit clients (#2 and #3). The findings are: A. Review on 11/18/24 of client #2's record revealed an IPP dated 10/23/23. Additional review of client #2's record revealed there was no	A BUILDING COM 34G103 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1050 HOGAN STREET FAYETTEVILLE, NC 28301 B. WING CROWLER COME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 did not have any formal training or goals. During an interview on 11/19/24, the Qualified Intellectual Disabilities Professional (QIDP) revealed a local neurological clinic had diagnosed client #4 with Severe Intellectual Disability. A follow up visit was conducted on 1/3/25. During morning observations in the home on 1/3/25 fith paragraph (c) of this section revealed dient #4 does not have any formal goals. During an interview on 1/3/25, the QIDP revealed he has not implemented any new goals for client #4. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. 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MY PLAC	CE				050 HOGAN STREET AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 260}	Continued From pa	ge 9	{W 26	60}			
	revealed an IPP date	3/24 of client #3's record ted 10/24/23. Additional record revealed there was no					
	Intellectual Disabilit confirmed, both clie updated IPP's. Fur	on 11/19/24, the Qualified ies Professional (QIDP) ents #2 and #3 did not have ther interview revealed that have not been rescheduled.					
	A follow up visit was	s conducted on 1/3/25.					
		f the Plan of Correction and #3 do hat have updated					
{W 263}	confirmed clients #2 IPPs.	on 1/3/25, the QIDP 2 and #3 do not have updated ORING & CHANGE (3)(ii)	{W 26	63}			
	are conducted only consent of the clien minor) or legal guar This STANDARD is Based on record refailed to ensure resconducted with the	s not met as evidenced by: eview and interview, the facility trictive programs were only written informed consent of a s affected 2 of 3 audit clients					
	Support Plan (BSP)	8/24 of client #2's Behavior), no date, revealed the d the BSP consent on 5/17/23.					

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		34G103	B. WING			R 02/2025
NAME OF F	PROVIDER OR SUPPLIER	0.70.100		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 HOGAN STREET FAYETTEVILLE, NC 28301		03/2025
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{W 263}	Further review rever medications. B. Review on 11/1 10/23/23, revealed BSP consent on 10 revealed client #3 h During an interview Intellectual Disability confirmed clients' # not have current writheir legal guardians. A follow up visit was Review on 1/3/25 or revealed clients #2 informed consent on During an interview confirmed clients #2 informed consent on DRUG USAGE CFR(s): 483.450(e) be used only as an individual program is specifically towards elimination of the beare employed. This STANDARD is Based on record refacility failed to ensiculients inappropriate an integral part of the second consent of the part of the second consent of the part of the p	aled client #2 has behavior 8/24 of client #3's BSP dated the guardian last signed the /25/23. Further review as behavior medications. on 11/19/24, the Qualified ies Professional (QIDP) 2 and #3 BSP consents did itten informed consent from s. s conducted on 1/3/25. If the Plan of Correction and #3 do not have written f their legal guardians. on 1/3/25, the QIDP 2 and #3 do not have written f their legal guardians. (2) integral part of the client's plan that is directed the reduction of and eventual ehaviors for which the drugs is not met as evidenced by: eview and interviews, the cure drugs used to manage is behaviors were used only as the Individual Program Plan id 1 of 1 newly admitted audit	{W 26			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G103	B. WING			l	R
NAME OF F	PROVIDER OR SUPPLIER	040100	1 2	S' 1	TREET ADDRESS, CITY, STATE, ZIP CODE 050 HOGAN STREET EAYETTEVILLE, NC 28301	<u> U170</u>	03/2025
(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 APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 312}	Review on 11/18/24	ge 11 , of client 4's record revealed ehavior medications without	{W 3 ⁻	12}			
	During an interview confirmed client #4 medications withou from his guardian.	on 11/18/24, the QIDP was receiving behavior tany written informed consent					
	Review on 1/3/25 or	s conducted on 1/3/25. If the Plan of Correction oes not have informed written uardian.					
{W 324}	confirmed client #4 written consent from	CES	{W 32	24}			
	examinations of each includes immunizated recommendations of Advisory Committees or of the Committee Diseases of the Am This STANDARD is Based on record refailed to ensure all in	ovide or obtain annual physical ch client that at a minimum ions, using as a guide the of the Public Health Service on Immunization Practices on the Control of Infectious erican Academy of Pediatrics. In some of the terms of the facility minimum interview, the facility minimum interview, the facility minimum interview in the facility in the facilit					
	he was admitted to	of client #4's record revealed the facility on 2/27/24. his record revealed no					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		34G103	B. WING		01	R / 03/2025	
NAME OF PROVIDER OR SUPPLIER MY PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1050 HOGAN STREET FAYETTEVILLE, NC 28301	, 0.	70072020	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
{W 324}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		{W 35				
	was admitted to the	4 client #4's record revealed e facility on 2/27/24. Review nt #4's record revealed he					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		2.2.2				R	
		34G103	B. WING			/03/2025	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE		
MY PLA	CE			1050 HOGAN STREET			
				FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	SHOULD BE COMPLÉTION	
{W 351}	review revealed clied during the examinal During an interview Intellectual Disabilit confirmed client #4 dental examination. the dental examination rescheduled. A follow up visit was Review on 1/3/25 or revealed client #4 hexamination. During an interview confirmed client #4 dental examination.	ge 13 xamination on 4/19/24. Further ent #4 was uncooperative tion and it was not completed. on 11/18/24, the Qualified ies Professional (QIDP) has not received a completed. Further interview revealed tion for client #4 has not been as conducted on 1/3/25. If the Plan of Correction has not received a dental on 1/3/25, the QIDP has not received a completed. Further interview revealed tion for client #4 has not been	{W 38	51}			