STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G120	A. BUILDING _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS FORK HOMES I AND II	1358 & 1388 LEWIS FORK BAPTIST CHURCH RD FERGUSON, NC 28624

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that privacy was maintained for 4 of 11 clients (#1, #3, #6, #9) during personal care. The findings are: A. Observation in Lewis Fork Home I on 2/5/25 at 7:02 AM revealed client #1 to be seated in a wheelchair in the doorway of the medication closet, which is situated adjacent to the kitchen/dining area of the home. Continued observation revealed staff A to conduct client #1's morning medication administration with the door of the med closet open to the common areas. During the entire med administration, client #6 stood directly behind client #1's wheelchair in the hallway. Subsequent observation revealed staff A to discuss the nature of each medication administered as well as the conditions for which client #1 is being treated. This conversation could be heard throughout the kitchen/dining areas, where several other clients and staff were seated or moving around. B. Observation in Lewis Fork Home I on 2/5/25 at 7:13 AM revealed client #6 to enter the same med closet and for staff A to conduct client #6's morning medication administration with the door of the med closet open to the common areas. Further observation revealed staff A to discuss the nature of each medication administered as well as the conditions for which client #6 is being treated. This conversation could be heard throughout the kitchen/dining areas, where	W 130		

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 130	Continued From page 1 several other clients and staff were seated or moving around. C. Observation in Lewis Fork Home II on 2/5/25 at 7:11 AM revealed staff B to prepare medications for client #3. Continued observation revealed staff B to knock on client #3's door and enter with medications in hand. Further observations revealed staff B and surveyor to enter client #3's bedroom and the client's bedroom door to remain partially open. Subsequently, staff B administered all morning medications to client #3 and exited the bedroom. D. Observation in Lewis Fork Home II on 2/5/25 at 7:25 AM revealed client #9 to be seated in a wheelchair in the doorway of the medication closet, which is situated adjacent to the kitchen/dining area of the home. Continued observation revealed staff B to conduct client #9's morning medication administration with the door of the med closet open to the communal areas. During the entire med administration, client #3 stood directly behind client #9's wheelchair outside the medication administration room. Subsequent observations during recertification survey on 2/4-2/5/25 revealed a non-recording monitor for client #9 to remain in the living room on the table next to the sofa. Continued observations revealed the non-recording monitor remained on the entire survey. Further observations revealed that client #9 was seen on the monitor anytime he entered his bedroom. At no time during the survey were staff observed to turn off or remove the monitor from the table. Interview on 2/5/25 with the qualified intellectual disabilities professional (QIDP) revealed that staff should be providing all clients with privacy during	W 130		

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W 130	Continued From page 2 medication administration. Continued interview with the QIDP revealed that clients with non-recording videos should have the monitor turned off during waking hours.	W 130		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations and interviews, the system for drug administration failed to assure 2 of 11 clients (#3 and #9) observed during medication administration were provided the opportunity to participate in medication self-administration or provide medication education. The findings are: Observation in Lewis Fork Home II on 2/5/25 at 7:11 AM revealed staff B to prepare medications for client #3 while in the medication administration room. Continued observation revealed staff B to knock on client #3's door and enter with medications in hand. Further observations revealed staff B and surveyor to enter client #3's bedroom and the client's bedroom door to remain partially open. Subsequently, staff B administered all morning medications to client #3 and exited the bedroom. At no point during the medication administration did staff prompt client #3 to assist with pouring water or popping her pills into a cup, nor did staff B provide client #3 with education. Observation in Lewis Fork Home II on 2/5/25 at	W 371		

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W 371	Continued From page 3 7:25 AM revealed client #9 to be seated in a wheelchair in the doorway of the medication closet, which is situated adjacent to the kitchen/dining area of the home. Continued observation revealed staff B to conduct client #9's morning medication administration with the door of the med closet open to the communal areas. Further observation revealed staff B to pop all morning pills into a medicine cup and prepare MiraLAX in plastic cup with water. At no point during the medication administration did staff prompt client #9 to assist with pouring water or popping her pills into a cup, nor did staff B provide client #9 with education. Interview on 2/5/25 with the qualified intellectual disabilities professional (QIDP) revealed that staff should give clients the opportunity to participate during medication administration. Continued interview revealed that staff should provide medication education to the clients during administration.	W 371		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure that adaptive equipment was furnished as prescribed for 1 of 11 clients (#9). The finding is: Observation in the group home during	W 436		

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W 436	Continued From page 4 recertification survey 2/4-2/5/25 revealed client #9 to participate in nail care, dinner meal, medication administration, and the breakfast meal. Continued observations revealed client #9 to not be provided with a helmet or gait belt. Further observations during medication administration revealed client #9 was not provided with a flo control cup during medication administration while receiving prescribed MiraLAX. At no point during the observation was client #9 provided with his helmet and gait belt. Review of records for client #9 on 2/5/25 revealed a person-centered plan (PCP) dated 9/3/24. Continued review of PCP revealed that client #9 is prescribed a helmet and gait belt to be worn during waking hours and a flo control cup to be used anytime the client needs to drink. Interview with the qualified intellectual disabilities professional (QIDP) on 2/5/25 confirmed client #9's PCP is current. Continued interview with the QIDP confirmed that the client should be provided with his adaptive equipment.	W 436		