STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G163	A. BUILDING _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS STREET HOME	348 THOMAS STREET JEFFERSON, NC 28640

(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 observations and interview, the facility failed to ensure privacy for 3 of 6 clients (#4, #5, and #6) during medication administration and personal care. The findings are: A. The facility failed to ensure privacy for client #6 during medication administration. For example: Observations in the home on 2/4/25 revealed the medication room adjacent to the kitchen and dining room area. Continued observation revealed client #6 to enter the medication room at 5:24 PM and the door to remain open for the duration of his medication pass. Further observation revealed at no time did staff administering medications to client #6 to close the door. Subsequent observation revealed all other clients sitting at the dining room table and some to exchange comments to client #6 while he received medications. Interview with the facility nurse on 2/5/25 revealed client #6 should be offered privacy during his medication pass. B. The facility failed to ensure privacy for clients #4, #5 and #6 during the treatment and care of personal needs. For example: Observations in the group home during the 2/4-5/25 survey revealed the bedroom windows for clients # 4, #5 and #6 have no window treatments to obstruct view into the room from	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 outside of the home. Continued observations revealed clients #4, #5, and #6 to sleep, dress, nap and spend leisure time in their bedrooms. Interview with staff A on 2/4/25 revealed the window blinds were removed and needed to be replaced as recommended by a recent home health inspection. Continued interview with staff A revealed the drapes were also taken down prior to getting the group home painted. Further interview with staff A revealed client's #4, #5, and #6 bedroom windows have been without a covering for quite some time. Interview with the qualified intellectual disabilities professional (QIDP) on 2/5/25 confirmed the blinds were removed following a recent health inspection and the home was recently painted. Continued interview with the facility administrator revealed they were unaware that the clients' windows were without covering and will be replaced.	W 130		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interview and record	W 249		

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W 249	Continued From page 2 review, the facility failed to ensure a continuous active treatment program consisting of needed interventions and services were implemented as identified in the person-centered plan (PCP) for client #4. The finding is: Observations throughout the 2/4/25 - 2/5/25 survey in the group home revealed client #4 to spend most of his time in his room. Continued observations on 2/4/25 from 4:00 PM - 4:49 PM revealed client #4 to sit in a recliner in the living room, then escorted to his room at 4:50 PM - 5:30 PM. Further observations on 2/5/25 from 6:55 AM - 8:28 AM revealed client #4 to remain in his room. Subsequent observations at 8:28 AM revealed staff to enter client #4's bedroom and prompt him to go to the bathroom to get changed. Additional observations did not reveal client #4 to be engaged in any other formal training or integrative activities throughout the observation period. Review of the record for client #4 on 2/5/25 revealed a person centered plan (PCP) dated 11/5/24. Continued review of the PCP revealed the following training objectives; socks worn on hands, privacy, dry face, dry hair, improve vocational skills, exit for fire drills, walk for exercise, cooperate with gum swabbing, collect shredded paper and behavior. Interview with the qualified intellectual disabilities professional (QIDP) on 2/5/25 revealed that client #4 should be involved in formal training and integrative activities in the facility throughout the day.	W 249		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1)	W 454		

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W 454	Continued From page 3 The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure staff use of proper gloves and to provide a sanitary environment to prevent cross contamination. This had the potential to affect clients (#1, #2, #3, #5 and #6) in the home. The findings are: A. The facility failed to ensure the proper use of gloves. For example: Observations on 2/4/25 during the dinner mealtime at 5:00 PM revealed staff B to wear gloves and apply alcohol-based hand sanitizer (ABHS) to clients #1, #2, #3, #5 and #6. Continued observations revealed staff B to then place all food on the table for the meal. Further observations revealed staff B to assist all clients with serving food onto their plates. At no time during the transition, did staff B change gloves. Interview on 2/5/25 with the facility nurse revealed staff should have changed gloves before and after assisting all clients apply the ABHS. B. The facility failed to ensure a sanitary environment to prevent cross contamination. For example: Observations in the group home during the 2/4/25 survey at 4:15 PM revealed client #3 to receive a prompt from staff to place the non-skid mats on the dinner table. Continued observations revealed client #3 to place the non-skid mats on the table	W 454		

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W 454	Continued From page 4 as instructed. Further observations at 4:30 PM revealed clients #1, #2, #3, #5 and #6 to sit at the dining room table to participate in a jewelry making activity until time for the dinner meal. Subsequent observations at 5:00 PM revealed a staff A to clear the activity from the table while staff B placed the dinner meal onto the table. At no point during the observations did anyone sanitize the dining room table. Interview on 2/5/25 with the facility nurse revealed staff should have provided a prompt for client #3 to complete hand hygiene before completing any food related activity. Continued interview with the nurse revealed staff should have a client to sanitize the table after the jewelry activity or should have wiped the table themselves before placing any food items on the table..	W 454		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served at an appropriate temperature for clients (#1, #2, #3, #5, and #6) residing in the facility. The finding is: Morning observations in the facility on 2/5/25 at 6:55 AM revealed staff to prepare the breakfast meal for the clients. The breakfast meal consisted of sausage biscuits, jelly and fruit. Continued observations revealed the food to remain on the kitchen countertop uncovered. Further observations at 7:20 AM revealed clients #3, #5 and #6 to prepare their breakfast plate in the kitchen with assistance from staff. Subsequent observations at 7:38 AM revealed	W 473		

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W 473	Continued From page 5 client #1 to prepare his breakfast plate in the kitchen. Observations at 7:55 AM revealed client #2 to prepare his breakfast plate in the kitchen with assistance from staff. Additional observations revealed the food to remain on the kitchen countertop for approximately 60 minutes. At no time during observations were the breakfast meal covered or kept warm until it was ready to be served. Interview with the qualified intellectual disabilities professional (QIDP) on 2/5/25 revealed staff should have kept the food covered and warm until it was ready to be served.	W 473		