| | | ID HUMAN SERVICES | | | | | MAPPROVED 0. 0938-0391 | |
|--------------------------|--|---|---------------------|-----|---|-------------------------------|----------------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` í | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 34G109 | B. WING _ | | | 03/ | 18/2025 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | 283 | REET ADDRESS, CITY, STATE, ZIP CODE 30 HIGHWAY 70 EAST .AREMONT, NC 28610 | | | |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| W 249 | each client must rece treatment program co interventions and ser and frequency to sup |) isciplinary team has ndividual program plan, ive a continuous active | W 2 | 249 | | | | |
| | Based on observatio interviews, the facility continuous active trea of needed interventio identified in the perso sampled clients (#1, # A. The facility failed to | o ensure that client #4's am was utilized in various | | | | | | |
| | recertification survey participate in various observations did staff communicate and tra activities throughout t Review of the record revealed a PCP dated the client has the follo communication pictur | activities. At no point during to use pictures to nsition the client to various he day. for client #4 on 3/18/25 d 4/15/24 which indicated | | | | | | |

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

TITLE

(X6) DATE

PRINTED: 03/20/2025

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.

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 03/20/2025 / APPROVED). 0938-0391 |
|--------------------------|--|--|---------------------|----|---|---|-----------|---|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` <i>`</i> | | CONSTRUCTION | | (X3) DATE | |
| | | 34G109 | B. WING | | | _ | 03/ | 18/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| PENNY L | ANE II | | | | 30 HIGHWAY 70 EAST LAREMONT, NC 2861 | 0 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| W 249 | professional (QIDP) of client #4's program of were current. Further revealed staff have be #4's communication pro- various activities. Cor QIDP verified staff shi communication pictur B. The facility failed to objectives relative to D Morning observations revealed client #1 to e observations revealed bathroom without was toileting. Continued of revealed client #1 to p and sit at the dining ta breakfast meal. Subs 7:10AM revealed client staff assistance and p meal without washing during the observation to sanitize or wash he Review of the record revealed a PCP dated the client has the folio hygiene goal, wiping washing goal. Continue client #1 revealed a b dated 4/1/24 which in vaginal and rectal dig Interview with the QIE program objectives an | lified intellectual disabilities in 3/18/25 verified that all of ojectives and interventions interview with the QIDP een trained to utilize client intuces to transition to nation to a transition to nation of the second states of the ould have utilized client #4's es as prescribed. In address of the second states of the outilize client #1's program handwashing. For example: on 3/18/25 at 7:00AM enter the bathroom. Further d client #1 to exit the shing her hands after bservations at 7:10AM blace her hands in her pants able to prepare for the equent observations at th #1 to serve her plate with harticipate in the breakfast her hands. At no point in did staff prompt client #1 er hands. for client #1 on 3/18/25 d 4/15/24 which indicated owing program goals: with toilet paper, and hand ued review of the record for ehavior support plan (BSP) dicated the client does | W 2 | 49 | | | | |

Facility ID: 922374

If continuation sheet Page 2 of 8

| | S FOR MEDICARE & | | | | | O. 0938-039 |
|---|--|--|--|--|----------|---------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | |
| | | 34G109 | B. WING | | 0 | 3/18/2025 |
| NAME OF PI | ROVIDER OR SUPPLIER | • | STI | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| PENNY LA | NE II | | | 30 HIGHWAY 70 EAST AREMONT, NC 28610 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| W 249 | Continued From page | e 2 | W 249 | | | |
| | verified staff have be | en trained to prompt client after toileting and prior to | | | | |
| W 341 | NURSING SERVICE CFR(s): 483.460(c)(5 | | W 341 | | | |
| | other members of the appropriate protective measures that include control of communication including the instruction imethods of infection This STANDARD is a Based on observation failed to implement at infection control for 4 | st include implementing with a interdisciplinary team, a and preventive health e, but are not limited to able diseases and infections, on of other personnel control. not met as evidenced by: ns and interview, the facility ppropriate methods of of 5 clients (#2, #3, #4, and ashing. The finding is: | | | | |
| | revealed staff to pron prepare for the break observations revealed plates without washin breakfast meal. Cont reveal staff to assist o | s on 3/18/25 at 7:15AM hpt clients to the table to fast meal. Further d clients to prepare their hg their hands prior to the inued observations did not or prompt clients (#2, #3, #4, hands in preparation for the | | | | |
| | qualified intellectual of (QIDP) on 3/18/25 re trained to wash their Further interview with | ogram manager (PM) and the disabilities professional vealed staff have been hands before all meals. In the PM revealed staff nts to wash their hands prior | | | | |
| W 474 | MEAL SERVICES CFR(s): 483.480(b)(2 | N/:::N | W 474 | | | |

Event ID: 7FUX11

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 03/20/2025 // APPROVED). 0938-0391 |
|--------------------------|--|---|-------------------|-----|---|--|-----------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` <i>'</i> | | E CONSTRUCTION | | (X3) DATE | |
| | | 34G109 | B. WING | | | | 03/ | 18/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STAT | E, ZIP CODE | | |
| PENNY L | ANE II | | | | 2830 HIGHWAY 70 EAST CLAREMONT, NC 28610 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX | (EACH CORRECT CROSS-REFERENC | LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY) | | (X5) COMPLETION DATE |
| W 474 | Continued From page | 3 | w | 474 | | | | |
| | developmental level of This STANDARD is r Based on observatio interviews, the facility form consistent with t of 3 sampled clients (are: A. The facility failed to prescribed. For exam Observations in the g 4:50 PM revealed the oz oven fried chicken cup green beans and water. Further observ client #1 to consume consistency. At no tim was staff observed to one inch consistency. Observations in the g 7:17 AM revealed the 2 muffins, 6 oz yogurf orange juice, water, a observations at 7:50 / consume her breakfa consistency. At no tim was staff observed to the meal in one inch of Review of client #1's a person-centered pla Further review of the occupational therapy 6-27-24 for client #1 t | not met as evidenced by: ns, record reviews, and failed to serve food in a he developmental level of 2 #1, and #3). The findings o follow client #1's diet as ple: roup home on 3/17/25 at dinner meal consisted of 3 , 1/2 cup potato salad, 1/2 texas cheese toast and ations at 5:40 PM revealed her dinner meal in whole he during the dinner meal assist the client to provide roup home on 3/18/25 at breakfast meal consisted of t, 1/2 cup strawberries, and milk. Further AM revealed client #1 to st meal in whole he during the breakfast meal assist the client to provide consistency. record on 3/18/25 revealed an (PCP) dated 4-15-24. | | | | | | |

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G109 B. WING 03/18/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2830 HIGHWAY 70 EAST PENNY LANE II CLAREMONT, NC 28610 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 474 Continued From page 4 W 474 skills. Interview with the program manager (PM) on 3/18/25 confirmed client #1's prescribed diet is current. Further interview with the PM confirmed specially modified diets should be followed as prescribed. B. The facility failed to follow client #3's diet as prescribed. For example: Observations in the group home on 3/17/25 at 4:50 PM revealed the dinner meal consisted of 3 oz oven fried chicken, 1/2 cup potato salad, 1/2 cup green beans and texas cheese toast and water. Further observations at 5:40 PM revealed client #3 to consume her dinner meal in whole consistency. At no time during the dinner meal was staff observed to assist the client to provide 1/2 inch consistency. Observations in the group home on 3/18/25 at 7:17 AM revealed the breakfast meal consisted of 2 muffins, 6 oz yogurt, 1/2 cup strawberries, orange juice, water, and milk. Further observations at 7:50 AM revealed client #3 to consume her breakfast meal in whole consistency. At no time during the breakfast meal was staff observed to assist the client to provide the meal in 1/2 inch consistency. Review of client #1's record on 3/18/25 revealed a person-centered plan (PCP) dated 1-6-25. Review of the PCP revealed an OT evaluation dated 12-3-24. Further review of the OT assessment revealed client #3 to be prescribed a regular diet, cut into 1/2 inch with thin liquids due to decrease in oral motor skills, coughing and signs of decreased chewing before swallowing.

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| | OF DEFICIENCIES | MEDICAID SERVICES | (X2) MULTIPLE | CONSTRUCTION | | O. 0938-039 |
|--------------------------|--|---|---------------------|---|----------------------------|----------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | . , | A. BUILDING | | |
| | | 34G109 | B. WING | | 0 | 3/18/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | | ST | REET ADDRESS, CITY, STATE, ZIP COE | DE | |
| PENNY LA | ANE II | | | 30 HIGHWAY 70 EAST _AREMONT, NC 28610 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | (X5) COMPLETIOI DATE |
| W 474 | Continued From page | e 5 | W 474 | | | |
| W 475 | #3's prescribed diet. PM confirmed specia followed as prescribe | | W 475 | | | |
| | This STANDARD is a Based on observation interviews, the facility received a continuous consisting of needed the Person-Centered providing adaptive eco | with appropriate utensils. not met as evidenced by: ns, record reviews and r failed to ensure clients s active treatment program interventions as identified in Plan (PCP) relative to guipment during mealtimes. npled clients (#3, #4). The | | | | |
| | at 4:35PM revealed s prepare for the dinne at 4:55PM revealed s for the dinner meal. C revealed client #3 to a plate, fork, and spo | ns in the facility on 3/17/25 staff to set the table to r meal. Further observations staff to sit clients at the table Continued observations have a full place setting with on and a teacup. At no point n did staff provide client #3 s prescribed. | | | | |
| | revealed staff to sit cl the dinner meal. Furt staff to provide client utensils: fork, spoon, | plate, and a teacup. At no rvation did staff provide | | | | |

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ____ 34G109 B. WING 03/18/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2830 HIGHWAY 70 EAST PENNY LANE II CLAREMONT, NC 28610 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 475 Continued From page 6 W 475 Morning observations on 3/18/25 at 7:00AM revealed staff to set the table for the breakfast meal. Further observation at 7:10AM revealed client #4 to sit at the dining table to prepare for the breakfast meal. Continued observations revealed staff to provide client #4 with the following utensils for the breakfast meal: fork, spoon, plate, and sports bottle without a lid. At no point during the observation did staff provide client #4 with a cup with a lid and straw as prescribed. Subsequent observations on 3/18/25 at 7:10AM also revealed client #3 to sit at the dining room table and participate in the breakfast meal. Further observation revealed client #3 to sit at the dining table and participate in the breakfast meal without a sports bottle as prescribed. Review of the record for client #3 on 3/18/25 revealed a PCP dated 1/6/25 and occupational therapy (OT) Evaluation dated 12/3/24 which indicated the client has the following adaptive equipment to use during mealtimes: sports bottle or cup with lid and straw. Review of the record for client #4 on 3/18/25 revealed a PCP dated 5/16/24 and OT Evaluation dated 3/28/24 which indicated the client is to use the following adaptive equipment during mealtimes: fork, spoon, plate, clothing protector, and cup with straw and lid. Interview with the qualified intellectual disabilities professional (QIDP) on 3/18/25 verified both clients #3 and #4's interventions and training objectives are current. Further interview with the QIDP revealed staff have been trained to provide adaptive equipment to the clients during

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 03/20/2025

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | PRINTED: 03/20/2025 FORM APPROVED OMB NO. 0938-0391 | |
|--------------------------|--|---|--|--|--|---|--|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 34G109 | B. WING | | _ | 03/18/2025 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, ST | TATE, ZIP CODE | | |
| PENNY LA | NE II | | | 2830 HIGHWAY 70 EAST CLAREMONT, NC 2861 | 0 | | |
| | | ATEMENT OF DEFICIENCIES | ID | | S PLAN OF CORRECTION | (X5) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRE) CROSS-REFERE | CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | COMPLETION | |
| 14/ 475 | | _ | | | | | |
| W 475 | Continued From page mealtimes as prescrib | | W 475 | | | | |
| | meanines as present | Jed. | | | | | |
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