PRINTED: 03/20/2025 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MILITIPLE COMPTRUETION		OMB NO. 0938-03	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		34G109	B. WING		1.	
PENNY L				STREET ADDRESS, CITY, STATE, ZIP CODE 2830 HIGHWAY 70 EAST CLAREMONT, NC 28610	1 0	3/18/2025
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ID DE	(X5) COMPLETION DATE
	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.		services identified in the individual program services in the interdisciplinary team has assert as a client's individual program plan, and time are client must receive a continuous active atthrese attment program consisting of needed atterventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program		in- ram action three the next	04/03/202
	Based on observations interviews, the facility facontinuous active treatr of needed interventions identified in the personsampled clients (#1, #4 A. The facility failed to expressions in the facility failed to expressions.	ailed to ensure that a ment program consisting were implemented as centered plan (PCP) for 2). The findings are: ensure that client #4's in was utilized in various				
From the control of t	Observations throughous recertification survey revolutions are participate in various acobservations did staff to communicate and transificativities throughout the Review of the record for evealed a PCP dated 4, the client has the following recertifications.	at the 3/17/25-3/18/25 vealed client #4 to tivities. At no point during use pictures to tion the client to various day. client #4 on 3/18/25 //15/24 which indicated ng program goals: goal, toileting goal, shoe		RECEIVED APR 0 1 2025 DHSR-MH Licensure S		-
RATORY DIR	ECTOR'S OR PROVIDER/SUP	PLIER 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7FUX11

Facility ID: 922374

If continuation sheet Page 1 of 8

STATEMENT	T OF DEFICIENCIES	(X4) PROVIDED BY				OMB	NO. 0938-0391
AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY
		34G109	B, WING			1.	242422
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 0	3/18/2025
PENNY L	ANE II			1.0000000	HIGHWAY 70 EAST		
				2657 34	AREMONT, NC 28610		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	10				
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	Interview with the qua professional (QIDP) or client #4's program ob were current. Further is revealed staff have be #4's communication pictures. Confugible various activities. Confugible verified staff sho communication pictures. B. The facility failed to objectives relative to his Morning observations revealed client #1 to endoservations revealed client #1 to play and sit at the dining table breakfast meal. Subsect 7:10AM revealed client staff assistance and particularly and without washing the observation of the sanitize or wash her in the client has the following the client has the following goal. Continued the client #1 revealed a behalted 4/1/24 which indicated 4/1/24 which indicated washing goal. Continued client #1 revealed a behalted 4/1/24 which indicated washing goal continued client #1 revealed a behalted 4/1/24 which indicated washing goal continued client #1 revealed a behalted 4/1/24 which indicated 4/1/24 which indicated washing the program objectives and	lified intellectual disabilities in 3/18/25 verified that all of ejectives and interventions interview with the QIDP interview with the QIDP interview with the QIDP interview with the QIDP interview of the very with the found interview with the build have utilized client #4's is as prescribed. utilize client #1's program andwashing. For example: on 3/18/25 at 7:00AM inter the bathroom. Further client #1 to exit the ining her hands after interventions at 7:10AM interventions int	Wa	249			
8	are current. Further inter	view with the QIDP					

STATEMENT OF DEFICIENCIES		T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL				OMB NO. 0938-0391	
AND PLAN OF CORRECTION		OF CORRECTION	IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
			34G109	B. WING				
		PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2830 HIGHWAY 70 EAST CLAREMONT, NC 28610	1 0	3/18/2025	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
	W 249 W 341	verified staff have bee #1 to wash her hands mealtimes. NURSING SERVICES	n trained to prompt client after toileting and prior to	W 24	(W341) Staff will be trained by	/ the	04/00/0000	
		other members of the illiappropriate protective ameasures that include, control of communicabi including the instruction imethods of infection of This STANDARD is not Based on observations failed to implement apprintection control for 4 of #5) relative to handwas Morning observations or revealed staff to prompt prepare for the breakfast observations revealed of plates without washing the breakfast meal. Continu	include implementing with interdisciplinary team, and preventive health but are not limited to le diseases and infections, of other personnel ontrol. It met as evidenced by: and interview, the facility propriate methods of 5 clients (#2, #3, #4, and hing. The finding is: In 3/18/25 at 7:15AM clients to the table to st meal. Further their hands prior to the		QP on ensuring hand washing occurs before every meal and needed throughout the day to ensure health and safety for a the home.	as	04/03/2025	
W	474	and #5) to wash their habreakfast meal. Interview with the prograqualified intellectual disa (QIDP) on 3/18/25 reveatrained to wash their har Further interview with the	am manager (PM) and the abilities professional alled staff have been ads before all meals. By PM revealed staff to wash their hands prior	W 474				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	T			OMB NO. 0938-039	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED	
		34G109	B. WING				
PENNY L	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2830 HIGHWAY 70 EAST CLAREMONT, NC 28610	1 0:	3/18/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(XS) COMPLETION DATE	
ti Fa	Food must be served developmental level of This STANDARD is in Based on observation interviews, the facility form consistent with the of 3 sampled clients (is are: A. The facility failed to prescribed. For example, the facility failed to prescribe facility fa	in a form consistent with the off the client. For met as evidenced by: Instruction, record reviews, and failed to serve food in a ne developmental level of 2 #1, and #3). The findings of follow client #1's diet as ole: Touch home on 3/17/25 at dinner meal consisted of 3 1/2 cup potato salad, 1/2 revease cheese toast and attions at 5:40 PM revealed for dinner meal in whole a during the dinner meal assist the client to provide to the provide of 1/2 cup strawberries, dinlik. Further of revealed client #1 to meal in whole during the breakfast meal saist the client to provide nearly the client to provide of 1/2 cup strawberries, dinlik. Further of revealed client #1 to meal in whole during the breakfast meal saist the client to provide nearly the client to provide	W 474	(W474) Staff will be trained QP on correct diet consister all individuals in the home to maintain health and safety. Mealtime assessments will be completed three times a most the next three months to mosfor correct consistency and ediets are followed per physic orders.	ncies for De Onth for Ditor Ensure	04/03/2025	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		INCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G109	B. WING				
NAME OF PROVIDER OR SUPPLIER PENNY LANE II			STREET ADDRESS, CITY, STATE, ZIP CODE 2830 HIGHWAY 70 EAST CLAREMONT, NC 28610		3/18/2025		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	MINDE	COMPLETION DATE	
W 474	Continued From page skills.	4	W 47	4			
	3/18/25 confirmed clie current. Further intervi specially modified diet prescribed. B. The facility failed to	gram manager (PM) on int #1's prescribed diet is lew with the PM confirmed is should be followed as follow client #3's diet as					
	Observations in the great- 4:50 PM revealed the coz oven fried chicken, cup green beans and to water. Further observationent #3 to consume he consistency. At no time	le: Dup home on 3/17/25 at Jinner meal consisted of 3 1/2 cup potato salad, 1/2 exas cheese toast and tions at 5:40 PM revealed					
0 0 0	2 muffins, 6 oz yogurt, 1 orange juice, water, and observations at 7:50 AM consume her breakfast i consistency. At no time i	reakfast meal consisted of /2 cup strawberries, I milk. Further I revealed client #3 to meal in whole during the breakfast meal sist the client to provide					
a R da as re	person-centered plan (Review of the PCP revea ated 12-3-24. Further re ssessment revealed clie	aled an OT evaluation eview of the OT ent #3 to be prescribed a nch with thin liquids due skills, coughing and					

STATEMENT	T OF DEFICIENCIES	I SERVICES				NO. 0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
V/44-		34G109	B. WING			
PENNY L				STREET ADDRESS, CITY, STATE, ZIP CODE 2830 HIGHWAY 70 EAST CLAREMONT, NC 28610	0	3/18/2025
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	II O DE	(X5) COMPLETION DATE
W 474	Continued From page	5	W 47	4		
	#3's prescribed diet. For PM confirmed specially followed as prescribed.	on 3/18/25 confirmed client urther interview with the v modified diets should be				
	CFR(s): 483.480(b)(2)(Food must be served with this STANDARD is not assed on observations interviews, the facility fareceived a continuous aconsisting of needed into the Person-Centered Pl	rith appropriate utensils. It met as evidenced by: It, record reviews and It is a constructed in the construction of the co	W 475	(W475) Staff will be in-servi the QP on all individuals' ad equipment needs and ensur- are being utilized appropriat times to ensure health and s	laptive re these tely at all	04/03/2025
f f r as do w	This affected two sample finding is: Afternoon observations at 4:35PM revealed staff prepare for the dinner mat 4:55PM revealed staff for the dinner meal. Concevealed client #3 to have a plate, fork, and spoon a during the observation divith a sports bottle as proceeding the observations.	in the facility on 3/17/25 If to set the table to eal. Further observations If to sit clients at the table tinued observations e a full place setting with and a teacup. At no point id staff provide client #3 escribed. s on 3/17/25 at 4:55PM #4 at the dining table for observation revealed with the following e, and a teacup. At no on did staff provide				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER PENNY LANE II (X2) MULTIPLE CONSTRUCTION A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 2830 HIGHWAY 70 EAST	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 03/18/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2830 HIGHWAY 70 EAST	(X5)	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PENNY LANE II 2830 HIGHWAY 70 EAST	(X5)	
PENNY LANE II 2830 HIGHWAY 70 EAST	E COMPLETION	
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CLAREMONT, NC 28610	E COMPLETION	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFLY (EACH CORRECTION)	E COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION)	ATE DATE	
W 475 Continued From page 6 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 clining 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 (OIDP) on 3/18/25 verified both clients #3 and #4/3 interventions and training objectives are current. Further interview with the OIDP revealed staff have been trained to provide adaptive equipment to the clients to during		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Lagorina		OMB NO. 0938-039
AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED.		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G109	B. WING		
PENNY L	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2836 HIGHWAY 70 EAST	03/18/2025
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		CLAREMONT, NC 28610	
PREFIX	I CACH DEFICIENT	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DE (FILE)
W 475	Continued From page	e 7			
	mealtimes as prescri	bed.	W 475		