		& MEDICAID SERVICES			FORM APPRO OME NO. 0938-
	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMEER)	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G204	E WING		0544 10000
NAME OF	PROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY STATE ZIP CODE	05/14/2025
WILSON	SMITH COTTAGE			35 MARTINDALE RD VINSTON SALEM, NC 27107	
(84) (2- DREFOX TAG	EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION (id PREFix 1771	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COUPLET
E 039	§460.84(d)(2), §482	(2) 3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2),		Wilson Smith Cottage ICF/IDD g will conduct exercises to test the emergency plan annually. The fa do all of the following:	acility will
	§483.475(d)(2), §48 §485.542(d)(2), §48 §485.920(d)(2), §48 §485.920(d)(2), §49 "(For ASCs at §416, at §485.542, OPO 1 §485.727, CMHCs a	34.102(d)(2), §485.68(d)(2), 15.625(d)(2), §485.727(d)(2), 11.12(d)(2), §494.62(d)(2), 54, CORFs at §485.68, REHs "Organizations" undar at §485.920, RHCs/FQHCs at Facilities at §494.62].	- - - -	Participate in a full-scale exerci- community-based every 2 years community-based exercise is no accessible, the group home will of facility-based functional excerciss in the event that Wilson Smith C axperiences an actual natural or emergency that requires activation mergency plan, the group home focument the evacuation as the pro- temergency plan.	and if a t conduct a e instead. cottage man-made on of the a will
	 to test the emergence must do all of the following (a) Participate in a full community-based even (A) When a community-conduct a exercise every 2 yea (B) If the [facility] 	I-scale exercise that is rery 2 years; or hily-based exercise is not a facility-based functional	ר - פ פ ג נו נו נו נו פו נו	Community-based or facility-base inctional exercise. The facility will conduct an additi xercises on the opposite year of cale or functional exercise. The xercise may be, but not limited to all scale exercise, a mock disast abletop exercise or workshop tha facilitator and includes a group of sing a narrative, clinically-relevan mergency scenario, and a set of altements directed mocanage	onal the full- adoitional o a second er drill, a t is led by discussion nt problem
	activation of the emer exempt from engagin community-based or i functional exercise for actual event.	rgency plan, the [facility] is	statements, directed messages, or prepared questions designed to challeng an emergency plan. An analysis of the emergency drill's response will be completed and revised as needed with documentation maintained.		nallenge Í the with
) { ! : : : : : : : : : : : : : : : : : :	years, opposite the years, opposite the years, opposite the year of the section is conductive: limited to the follow A) A second full-scale community-based or in unctional exercise; or B) A mock disaster dr C) A tabletop exercise	ear the full-scale or ider paragraph (a)(2)(i) of led, that may include, but is wing: e exercise that is individual, facility-based	ex ap ful fac em	vidence of completed emergency ercises will be documented on a propriate form. The form shall in what type of exercise was practi- l scale community-based, function ility-based, actual natural or main ergency, mock disaster drill, or the tabletop exercise/workshop. - each type will have a description in staff's understanding of proc	n nclude: onai n-made facilitator

Any dependency statement ending with an asteriask (1) denotes a dialiciency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Excaption nursing homas, the lindings stated above are disclosable 90 days class following the date of survey whether or not a plan of correction is provided. For hursing normas, the above findings and plans of correction are disclosable 14 integration provided to the set of the set

F. B** CMS-2567/02-94: Pm.-c. is Versions Description

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Exection No-21.

Factory (D. 92163)

ITATEMENT OF DEFICIENCIES NO FLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	-X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346204	B WING	05/14/202
NME OF PROVIDER OR SUPPLIER		STREET ADDRESS CITY STATE ZI 185 MARTINDALE RD WINSTON SALEM. NG 27107	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE A TAG CROSS REFERENCED TI DEFICIE	CTION SHOULD BE COMPLE O THE APPROPRIATE 041
 a narrated, clinically-scenario, and a set of directed messages, of designed to challeng (iii) Analyze the [facili maintain documentation exercises, and emergifacility's] emergency "[For Hospices at 418 (2) Testing for hospic patient's home. The test is the exercises to test the exercises to test in a full community based everes (A) When a community based everes (B) if the hospice export man-made emergency plan, the energency clinity-based functional onset of the emergency (i) Conduct an addition opposite the year the following: (A) A second full-scale community-based or a exercise; or (B) A mock disaster drives a second clinity of the following: 	des a group discussion using relevant emergency of problem statements or prepared questions e an emergency plan, ity's] response to and ion of all drills, tabletop gency events, and revise the plan, as needed. 3.113(d)() resisthat provide care in the hospice must conduct emergency plan et lenst e must do the following -scale exercise that is ery 2 years; or y based exercise is not i in individual facility based ery 2 years; or eriences a natural or y that requires activation of the hospital is exempt from quired full scale rcise or individual al exercise every 2 years, ull-scale or functional aph (d)(2)(i) of this section include, but is not limited exercise that is facility based functional include, but is not limited exercise that is facility based functional	E 039 (2) date, time, and leng (3) a list of client and st (4) the facilitator of the (5) the location of the d (6) a detailed narrative group discussion (7) written clinical-relate (as appropriate) (8) written set of problet directive messages, questions (8) analysis of participal (9) suggestions for impr "This form shall be sepa monthly fire Rehearsal f It will be reviewed and s Program Manager and/o completion.	laif participants drill of the drill or ed scenerios uses m statement, and prepared les response ovements arate from the Report, joned by the

CENTERS FOR		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPRON
ATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER		OFLE CONSTRUCTION	OMB NO. 0936-00 (X3) DATE SURVEY COMPLETED
		34@204	a iving j		6714 - 1990 r
IAME OF PERIVIDER	OR SUPPLIES.	and a second		STREET ADDRESS CITY, STATE ZIP CO	05/14/2025
VILSON SMITH C	-74.5.		ł	185 MARTINDALE RD	
ALCONDICT HO	JI TAGE		Ì	WINSTON SALEM, NC 27107	
	EACHINEROUGH	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FOLL R LISC IDENT/SYING INFORMATION	D ESEEL TAB	PROVIDER'S PLAN OF C IEACH CORRECTIVE ACTIO CROSS-REFERÊNCED TO TH DEFICIENCY	EAPPROPRIATE
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		-relevant emergency	1. (),		
scenari	o, and a set	of problem statements.			
directed	messages.	or prepared questions			
designu	a to challeng	ge an emergency plan.			
111 Test	ine for boshi	ces that provide inpatient			
care da	activ. The h	ospice must conduct			
		emergency plan twice per			
year. T	ne hospice n	nust do the following:			
(i) Parti	cipate in an	annual full-scale exercise inst			
	unity-based:				
(A) Whe	n a commun	ity-cased exercise is not			
		an annuai individus!			
		nal exerciser or periences a natural or			
0130-012	The emergen	cy that requires activation of			
the eme	aency plan	the hospice is exempt from			
engagin	in its next r	equired full-scale community			
based of	tacility-base	ed functional exercise			
following	the onset of	the emergency event			
(ii) Cone	luct an adoit	ional annual exercise incl			
inay incli	ide, but is no	st limited to the following:			
		le exercise mat is			
commun exercise		a facility based functional			
	or ok disaster o	Trill or			
		se or workshop led by a			
iacilitator	that include:	s a group discussion using a			
narratec.	clinically-rei	evant emergency scenario.			
and a set	of problem s	statements, directeci			
message	s, or propare	d questions designed to			
challenge	an emerger	icy plan.			
(m) Analy	ze the nospi	ce's response to and			
oreiotam i	iocumentatic	on of all drills, tabletop			
nusning/s	and emerge	ency events and revise the plan las needed			
in a pice in	emaryunoy (Addit dis fateo sta			

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	JE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION	OMB NO. 0938- COLDATE SURVEY DOME ETED
			1		
		340204	H WING		05/14/2025
THUS OF PR	OMIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP (
WILSON S	MITH COTTAGE		ļ	135 MARTINDALE RO	
			÷	WINSTON SALEM, NO. 27167	
(X4)10 FREFLS (V)3	TEACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL PLSC IDENTIFYING INFORMATION I	D PEFF X 140	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT OROSS-REFERENCED TO T OFFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DOTE
E 039	Continued From pag	na 3	- 0	20	
		1.164(d), Hospitals at	E 0.	(9	
	\$482.15(c), CAHs 2				
		TF, Hospital, CAHj must			
	conduct exercises to	test the emergency plan			
	wice per year. The to the following:	(PRTF Hospital, CAH) must			
		annual fuil-scale exercise ma:			
	s community-based;				
(A) When a commun	ity-based exercise is not			
c	accessible, conduct a	an annual individual,			
ť	aciiity-based function	nal exercise; or			
!	6) If the [PRTF, Hos	pital. CAH) experiences an			
÷	ictual natural or man	n-made emergency that			
6	equires activation of	the emergency plan, the			
1	equired full-scale co-	m engaging in its nex: mmunity based or individual.			
12	cility-based function	nal exercise following the			
0	naet of the emergen	icv event			
		additionalj annuai exercise ni			
	nd that may include	but is not limited to the			
	llowing:				
	A) A second full-sca				
66	emmunity-based or i inclianal exercise; or	ndividual, a facility-based			
15		nsaster drill; or			
		ercise or workshop Inpt is			
10	d by a rabilitator and				
		irrated clinically-relevan			
		and a set of problem			
ist	atements, orrected n	nessages, or prepared			
(11. jali	lestions besigned to	chailenge an enlergency			
		ecility's response to and			
716	Untain documentatio	on of all critis, tabletop			
сь. Па	ordises. And amerge cility's] emergency p	ency events and revise the lan, as needed			
	or PACE at §460.84				
+ 2 E C					

CALL AND DRA	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	13.213.111	TELECON	STRUCTION	OMB_NO. 0938-1
04144-0	CORRECTION	OFNTIFICATION NUMPER			and show	(N3) DATE SURVEY COMPLETER
		34G204	+ W45			
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					ARTINDALE RU	
HLSON S	MITH COTTAGE				TON SALEM, NC 27107	
34153 - 3563 - 255	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NOV MUST BE PRECEDED BY FULL IR USE IDENTIFYING INFORMATION)	- 316F 12 - 316F 12 - 7.03	<	PROVIDER'S PLAN OF CORRECTIO (SACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBC COMPLEX
7/39	Continued From pa	ine A				
			€ O	39		
	(2) lesting. The PA	CE organization must conduct				
	exercises to test the	e emergency plan at least				
		E organization must do the				
	following: w Participata in an	one well full and the second second				
	Participate in an is community-pased	annual full-scale exercise that				
		i, or nity-based exercise is not				
		nity-based exercise is not I an annual individual				
	facility-based function					
	(B) If the PACE evol	eriences an actual natural of				
	Wan-made emercer	ncy that requires activation of				
	the entergency plan	. the PACE is exempt from				
	encacinu în us next	required full-scale community				
	pased or individual.	facility-based functional				
		le onset or the emergency				
	vent.	is a four of the unisigency				
	tin Conduct an a	additional exercise every 2				
1	ears opposite the vi	ear the full-scale or functional				
e	xerciso under parag	graph (d)(2)(i) of this section				
	s conducted that ma	ly include, but is not timited to				
1	he following:					
(A) A second full-sca	ale exercise that is				
2	ommunity-based or	individual, a facility based				
4	inctional exercise; c	»,				
	e). A mock disaster					
	3 A tabletop exerci	ise or workshop that is led by				
63	acilitator and inclui	des a group discussion.				
Û.	sing a narrated, clin	ically-relevant emergency				
5,	cenarie, and a set o	problem statements,				
C	récleo messages, o	ir prepared questions				
a	esigned to challenge	e an emergency plan.				
(1)	in Analyze the PAC	E's response to and				
<i>a</i> :	amentati	ion of all drills, tabletop				
9. P.	ACE's emergency pl	ency events and revise the lan, as needed.				
	For LTC Facilities at	§483.73(d):] hust conduct exercises to				

			1	and a second	OMB NO. 0938-0
ND FLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G204	5 WING		05/14/2025
VANE OF F	POVIDER OR SUPPLIER	and a second	STREET ADDRESS, CITY, STATE, ZIP CODE		00114/2023
WILSON SMITH COTTAGE			1	ES MARTINDALE RD VINSTON SALEM, NC 27107	
(X4) /D PREFIX 74.6	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FUIL R LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTI EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DESCRENCY-	D BC DOVELLING
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	emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commun accessible, conduct facility-based functio (B) if the [LTC facility actual natural or mar- requires activation of LTC facility is exemp required a full-scale i individual, facility-based following the onset of (ii) Conduct an additi may include, but is ni (A) A second full-scale community-based or functional exercise; of (B) A mock disaster (C) A tabletop exercise a facilitator includes a facilitator includes harrated, clinically-rel sold a set of problem massages, or prepare challenge an emerged (iii) Analyze the [LTC and maintain docume	annual full-scale exercise that ; or inity-based exercise is not an annual individual; inal exercise. and exercise. and exercise. and exercise an inmade emergency that if the emergency plan, inclu- t from engaging its next community-based or sed functional exercise if the emergency event ional annual exercise that on individual; facility based r bill exercise that is an individual; facility based r aniti; or se or workshop that is ied by a group discussion, using a evant emergency scenario, statements, directed ac questions designed to noy plan. facility] facility's response to intation of all onits, tabletop ency events, and revise the			

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		& MEDICAID SERVICES			FORM APPRON OMB NO: 0938-03
ATEMENT OF I C PLALLOF CO	DEFICIENCIES DPRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT:FICATION NUMBER	(X2) MULTIPLE C A SUILOING	CONSTRUCTION	COMPLETED
		34G204	2 WING		05/14/2025
MULE OF PROV	IDER OR SUPPLIER	n 1999a hanagi afanggaya di na si disemba 1946 di da si Al-Mandi daké a ma da ki dana da ma	577	EET ADDRESS, CITY, STATE, ZIP CODE	00/19/2025
VILSON SM	TH COTTAGE		185	MARTINDALE RD	
			WI WI	STON SALEM, NC 27107	
(XAND PREFIX TAS	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION:	50 FREFix 17.34	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE OPOSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 039 Co	onunuen From pa	ga 6	E 039		
15	community-pased	t: or			
	da se da se de	nity-based exercise is not			
ac	cessible, conduct	an annual individual.			
	ility-based functio				
		periences an actual natural or			
		by that requires activation of			
000 200	energency plan	, the ICF/IID is exempt from required full-scale			
CO	mmunily-based or	individual, facility-based			
		ollowing the onset of the			
en	ergency event.				
		ional annual exercise that			
ma	y include, but is n	ict limited to the following:			
		le exercise that is			
		an individual, facility-based			
	ctional exercise: c				
	A mock disaster i	anii) or se or workshop that is led by			
		des a group discussion.			
		ically-relevant emergency			
sce	nario, and a set o	f problem statements,			
		or prepared questions			
		e an emergency plan			
(11)	Analyze the ICF/I	ID's response to and			
		ion of all drills, tabletop			
		ency events, and revise the			
ICF.	ID's emergency	pian, as needed			
	r HHAs at §484.1				
		HA must conduct exercises			
to ie	st the emergency	plan at			
leas	annually. The H	HA must do the following			
	erticipate in a full- munity-based; or	scale exercise that is			
		nunity-based exercise is not			
adde	ssible, conduci a	n annual individual.			
locit	uppend function	the second s			
GGS	ty-based lunction	al exercise every 2 years;			

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if continuation sheet Popul 7 of 19

CENTERS FOR ME	DICARE & MEDICAID	SERVICES			FORM APPRO OMB NO. 0938-0
TATEMENT OF DEFICIENCI ND PLAN OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G204	B WING	And the second distance of the second second	05/14/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CIT		STREET ADDRESS, CITY, STATE, ZIP	and the second sec		
	N SMITH COTTAGE			185 MARTINDALE RD	
WILSON SMITH COTTA	AGE			WINSTON SALEM, NC 27107	
PREFIX (EAC	SUMMARY STATEMENT OF D H DEFICIENCY MUST BE PRE JLATORY OR LSC IDENTIFYIN	CEDED BY FULL	D PREFD TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
E 039 Continued			50	20	
		n actual actual	EO	39	
	the HHA experiences a de emergency that req				
	gency plan, the HHA is				
engaging ir	its next required full-s	cale			
community	based or individual, fa	cility based			
	xercise following the o	nset of the			
emergency					
	an additional exercise				
	e year the full-scale der paragraph (d)(2)(i)	or functional			
is conducte	• • • • • • • • • • • • • • • • • • • •				
limited to th					
(A) A s	econd full-scale exercis	se that is			
community-	based or an individual,	facility-based			
functional e					
	lock disaster drill; or				
	bletop exercise or wor				
	litator and includes a g				
	using a narrated, clinic scenario, and a set of j				
	directed messages, or				
	esigned to challenge a				
plan.	Ū Ū	,			
	the HHA's response to				
	on of all drills, tabletop				
	events, and revise the	HHA's			
emergency (olan, as needed.				
	at §486.360]				
(d)(2) Testing	g. The OPO must cond	uct exercises			
	nergency plan. The OF	O must do the			
following:					
(I) Conduct a	paper-based, tabletop	exercise or			
led by a facil	least annually. A table itator and includes a gr	op exercise is			
	ising a narrated, clinica				
	cenario, and a set of p				
	directed messages, or				
	.	2 - 19 January 201			
CNS-2567(02-99) Previous V	atsions Obsolate	Event ID N/H311		acity ID 921533	If continuation cherry from a new

Event ID: N/H311

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If continuation sheet Page 8 of 18

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NIJMBER		TIPLE CONSTR		(X3) DATE SURVEY
		346204	8 WING			
NAME OF	PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP CODE	05/14/2025
WILSON	SMITH COTTAGE			185 MARTH	NDALE RD	
				WINSTON	SALEM, NC 27107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIO TE DATE
E 039	Continued From pag	e 8	ΕO	20		
		to chailenge an emergency		39		
	plan. If the OPO exp	eriences an actual natural or				
	man-made emergen	cy that requires activation of				
	the emergency plan,	the OPO is exempt from				\$
	engaging in its next r	equired testing exercise				
	(ii) Analyze the OPO	f the emergency event. 's response to and maintain				
	documentation of all	tabletop exercises, and				
	emergency events, a	nd revise the [RNHCI's and				
	OPO's] emergency pl	lan, as needed.				
	"[RNCHIs al §403.74	18]:				
	(d)(2) Testing. The RM	NHCI must conduct				
		emergency plan. The RNHCI				
	inust do the following:					
	least annually. A table	ased, tabletop exercise at etop exercise is a group				
	discussion led by a fai	cilitator, using a narrated.				
	clinically-relevant eme	rgency scenario, and a set				
	of problem statements	, directed messages, or				
	prepared questions de	esigned to challenge an				
	emergency plan.	constant and constant an				
	(ii) Analyze the RNHC	is response to and on of all tabletop exercises.				
	and emergency events	s, and revise the RNHCI's				
3	emergency plan, as ne	eded				
0	This STANDARD is no	of met as evidenced by:				
	Based on record revie	w and interview, the facility				
1	ailed to conduct bienn	ial testing of the facility's				
f	emergency preparedne inding is:	ess plan (EPP). The				
F	Review on 5/13/25 of th	ne facility's EPP revealed				
r	to evidence of a full-sc	ale community or				
í	acility-based training, a	a second full				
s	cale-community or fac nock drill, or tabletop e	ility-based training or version				
ir	iterview on 5/14/25 wit	th the qualified intellectual				

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/16/20 FORM APPROV OMB NO: 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G204	B WING		05/14/2025
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	00/14/2023
WILSON	SMITH COTTAGE			185 MARTINDALE RD WINSTON SALEM, NC 27107	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
E 039	Continued From page	9	E 03	9	
W 260	facility has no evidence community or facility-b		W 26(
	CFR(s): 483.440(f)(2) At least annually, the i must be revised, as ap process set forth in par This STANDARD is no Based on record revie facility failed to have er support plans (BSP's) i (#1, #2, #3 and #5) we least annually as requir A. The facility failed to at least annually for clie Review of records for c revealed a BSP dated for the review year of 20 B. The facility failed to r at least annually for clie Review of records for c revealed a BSP dated for the review frecords for clie Review of records for clie review revealed client # for the review year of 20 review revealed client #	ndividual program plan opropriate, repeating the ragraph (c) of this section. of met as evidenced by: ews and interviews, the vidence that the behavior for 4 of 5 audited clients re revised and updated at red. The findings are: revise and update the BSP ent #1. For example: dient #1 on 5/14/25 1/16/24. Continued record #1 to have no current BSP 025. revise and update the BSP ent #2. For example: lient #2 on 5/14/25 11/9/19. Continued record 2 to have no current BSP		No less than annually, all clients of 1 Smith Cottage will have their individ program plan revised, as appropriat individual program plans shall includ Behavior Support Plans. The Program Director/Qualified Professional will conduct routine Interdisciplinary Team meetings to a the consultative review and progress update discussions. Prog Dir/QP will ensure that a licensed psychologist istaffed as a specialized consultant of IDT. Prog Dir/QP will ensure the ann and as needed revisions to the BSP completed in a timely fashion by the consulting psychologist. Once subm Prog Dir/QP will present the BSP to Human Rights Committee and guard the individuals and obtain signatures approval and consent.	ual e. de a allow s i is no the ual are itted, the the
	It least annually for clier Review of records for cli	and a second			

Event ID NIH311 Facility ID 021983

If continuation sheet Page 10 of 18

	T OF DEFICIENCIES	& MEDICAID SERVICES	1			DRM APPRO NO. 0938-0
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	PLE CONSTRUCTION G		ATE SURVEY
		34G204	B WING			5/4 4/2025
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		05/14/2025
WILSON	SMITH COTTAGE			185 MARTINDALE RD		
			·	WINSTON SALEM, NC 27107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	IÐ PREFIX VAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	IX5 COMPLET DATE
W 260	Continued From pag	ne 10	11/00	10		
		ed 10/13/19. Continued	W 26	0		
		ed client #3 to have no				
	current BSP for the r					
	D. The facility failed	to revise and update the BSP				
	at least annually for	client #5. For example:				
	revealed a BSP date	r client #5 on 5/14/25 d 2/5/19. Continued record it #5 to have no current BSP 2025.				
₩ 262	disabilities profession BSP's for client #1, #2 updated due to the fa position. Further inte	hould have an updated BSP	W 262	No less than annually, all clien Smith Cottage will have their ir	Idividual	07-01-20.
	monitor individual prog inappropriate behavio in the opinion of the co- client protection and ri This STANDARD is n- Based on review of re facility failed to obtain human rights committee for 4 of 5 audited client finding are:	ot met as evidenced by: ecords and interviews, the written consent from the ee (HRC) at least annually ts (#1, #2, #3 and #5). The obtain an annual HRC		program plan revised as appro- Individual program plans shall Behavior Support Plans that is manage inappropriate behavio individual program plan's BSP programs that involve risks to c protection and rights) shall be reviewed, approved and monito The Prog Director/Qualified Pro- will conduct routine Interdiscipli meetings to allow the consultat and progress update discussion Dir/QP will ensure that a license psychologist is staffed as a spe consultant on the IDT. Prog Dir ensure the annual and as need to the BSP are completed in a t	include a designed to r. The (and other lient ored. ofessional nary Team ive review ns. Prog ed cialized 'QP will ed revisions imely	
				fashion by the consulting psych	oloniet	

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Event ID: NIH311

Facility (D 921953

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8			FORM APPROVE
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	34G204	B WING	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP	05/14/2025 CODE
VILSON SMITH COTTAGE		185 MARTINDALE RD WINSTON SALEM, NC 27107	
PREFIX (EACH DEFICIENC	IATEMENT OF DEFICIENCIES 27 MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
 have no current HRC of 2025. B. The facility failed to consent for client #2. Review of records for revealed an HRC consection of 2025. C. The facility failed to consent for client #3. Review of records for crevealed an HRC consection of 2025. D. The facility failed to consent for client #5. D. The facility failed to consent for client #5. Review of records for client #6. D. The facility failed to consent for client #5. Review of records for client #6. D. The facility failed to consent for client #5. Review of records for client #6. 	esent dated 5/15/24. iew revealed client #1 to consent for the review year b obtain an annual HRC For example: client #2 on 5/14/25 sent dated 11/19/19. ew revealed client #2 to consent for the review year obtain an annual HRC For example: client #3 on 5/14/25 sent dated 10/13/19. w revealed client #3 to onsent for the review year obtain an annual HRC for example: client #5 on 5/14/25 sent dated 2/5/19. w revealed client #5 to onsent for the review year bbtain an annual HRC for example: consent for the review year bbtain an annual HRC for example: consent for the review year bbtain an annual HRC for example: consent for the review year h the qualified intellectual (QIDP) confirmed the #1, #2, #3 and #5 have the facility's vacant	W 262 and guardian of the indivision signatures of approval am- Further measures will be the Extended Reach data bas LSC personnel uploads a the E-Reach system will re the HRC's and guardian's been obtained.	dual and obtain d consent. laken by LSC's e system. When BSP document. equest if both
QIDP confirmed all client updated HRC consent at	Is should have an		1

FOR ous Versions Obsolete

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CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		FORM APP OMB NO. 093				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVE COMPLETED				
	34G204	8 WING					
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO	1 05/14/202				
WILSON SMITH COTTAGE		185 MARTINDALE RD					
THE CONTRACT AND		WINSTON SALEM, NC 27107					
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CO	APPECTION				
	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPL EAPPROPRIATE DAY				
W 263 PROGRAM MONITOR CFR(s): 483.440(f)(3)(RING & CHANGE	W 263 No less than annually, all cl	ients of Wilson 07-01-				
CFR(5) 403.440(1)(3)(11)	Simili Collade will have the	ir individual				
The committee should	insure that these programs	program plan revised, as ap The Program Director/Quali	propriate.				
are conducted only with	h the written informed	Protessional will conduct an	annual and/or				
consent of the client, pl	arents (if the client is a	as needed treatment team /	committee				
minor) or legal guardiar	n.	meetings to review, and repu	ort client's				
This STANDARD is no	t met as evidenced by:	Client quardian and staffed	progress. Prog Dir/QP will ensure that the client, guardian, and staffed licensed				
Based on review of rec	cords and interviews, the	professionals / specialized c	onsultante				
facility failed to obtain w	written consent from the	allend the treatment team / (antimmo				
guardians at least annu	ally for 4 of 5 audited	meeting. Prog Dir/QP will ensure the annual and/or as needed revisions to the individual					
clients (#1, #2, #3 and #	(5). The linding are:	program plan are completed.	o the individual				
A. The facility failed to c	blain an annual quardian	to the treatment team / comm	nittee meating				
A. The facility failed to obtain an annual guardian consent_for client #1. For example:		will sign the plan's signature	page.				
Review of records for cli	ent #1 on 5/14/25						
revealed a guardian con	sent dated 5/15/24						
Continued record review	revealed client #1 to						
have no current guardian year of 2025.	n consent for the review						
B. The facility failed to ot	otain a annual guardian						
consent for client #2. Fo	r example:						
Review of records for clie	ent #2 on 5/14/25						
revealed a guardian cons	sent dated 11/19/19						
Continued record review	revealed client #2 to						
have no current guardian year of 2025.	consent for the review						
C. The facility failed to ob	tain a annual guardian						
consent for client #3. Fo	r example:						
Review of records for clier	nt #3 on 5/14/25						
revealed a guardian conse	ent dated 10/13/19						
Continued record review r	evealed client #3 to						
have no current guardian year of 2025	consent for the review						
MS-2567(02-99) Previous Versions Obsciete	and the second data						

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			FC	TED: 05/16/2 RM APPROV NO: 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) D/	ME SURVEY
		34G204	5 WING			
NAME OF	PROVIDER OR SUPPLIER			STREEY ADDRESS, CITY, STATE,	ZIP CODE	5/14/2025
WII SON	SMITH COTTAGE			185 MARTINDALE RD		
	omini contac			WINSTON SALEM. NC 27107	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	PROVIDERS PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	TO THE APPROPRIATE	(XS) COMPLETIC DATE
W 263	Continued From pag	be 13	W 2	63		
		to obtain a annual guardian	VV 2	03		
	consent for client #5	5. For example:				
		or client #5 on 5/14/25				
	revealed a guardian	consent dated 2/5/19.				
	Continued record rev	view revealed client #5 to				
	year of 2025.	dian consent for the review				
	Interview on 5/14/25	with the qualified intellectual nal (QIDP) confirmed the				
	guardian consent for	client #1, #2, #3 and #5 has				
	not been updated due	e to the facility's vacant				
	psychologist position.	Further interview with the				
	QIDP confirmed all cl	ients should have an				
11 200	updated guardian cor	isent at least annually.				
W 369	DRUG ADMINISTRAT CFR(s): 483.460(k)(2		W 36	9 Wilson Smith Cottage sh	hall have in place a	07-01-202
	CFR(5). 403.400(K)(2)		system for drug administ	tration that will	
	The system for drug a	administration must assure		assure that all drugs, inc are self-administered are	administered	
	that all drugs, includin	g those that are		without error		
	self-administered, are	administered without error.		Wilson Smith Cottage's i	dentified system	
	This STANDARD is n	ot met as evidenced by:		utilizes the assistance of Buddy system will require	e a co-worker to	
	Based on observation	n, record review and		verify that all medications	s have been	
	were administered with	ailed to assure all drugs hout error for 1 of 5 clients		administer and documen	ted Daily	
	(#5) observed during r	nedication administration.		immediatly after each an passes (AM,PM) a secon	d all medication	
	The finding is:	dentification.		shint will inspect all medic	ation bubble nacks	
				to ensure each day's mer	d is no longor	
(Diservation in the group home on 5/14/25 at 7:46 M revealed staff D to assist client #5 to punch nedications into a medicine cup during			present. (Note that tablet	s are popped out	
				(ne current day's date.) A	dditionally the	
r	medication administrat	ion. Continued		buddy will inspect the MA	R to ensure all	
c	observation revealed th	he client to take all		documentation (initials, PF etc.) is present.	KN descriptions,	
r	nedications whole with	water. Further				
C	bservations revealed	client #5 to take prescribed		Wilson Smith Cottage will	provide trainings	
0	nouth rinse to bathroom	m and brush on his teetn.		to staff members administ annually and when a need	tering medications	
5	Subsequent observatio	ins in the bedroom		action is identified.	a for correc(ive	
115,2567/0	(2-93) Providus Versions Obsole	te Event ID Nar311		ahiy ID 921583		

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Facility ID 921583

If continuation sheet Page 14 of 18

		& MEDICAID SERVICES			PRINTED: 05/16/ FORMAPPRO	
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G204	B WING_			
NAME O	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/14/2025	
WIII CO			1	185 MARTINDALE RD		
MLSU	N SMITH COTTAGE			WINSTON SALEM, NC 27107		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID ID			
PREFIX TAG	EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE	
W 36	9 Continued From pa	oe 14				
			W 36	9		
	cream to his back a	apply the client's medicated				
	SICON TO THE DECK &	sionach.				
	Review of records for	or client #5 on 5/14/25				
	revealed physician (orders dated 5/1/2025.				
	Review of the 5/1/20	025 physician orders revealed				
	medications to admi	inister at 8:00 AM to be				
	Chlorhexidine 0.12%	6 rinse, Hydrocortisone 2.5%				
	cream, Qc multi Vite	tab 130, Risperidone 0.5				
	Mg, Risperidone 1 M	Ag. Sertraline Hcl 100 Mg.				
	Sertraline Hcl 50 Mo	and Tamsulosin Hcl 0.4 Mg.				
	During the medicatio	on administration observation				
	staff D was not obse	rved to administer, Qc multi				
	Vite tab 130, Risperi	done 1 Mg, Sertraline Hcl				
	100 Mg, and Sertrali	ne Hcl 50 Ma.				
	Interview with the qui	alified intellectual disabilities				
	professional (QIDP) (on 5/14/25 verified the				
	physician orders date	ed 5/1/2025 to be current				
	Continued Interview	with the QIDP revealed that				
	the facility was in the	process of changing				
	pharmacies due to the	e discrepancies with the				
	physician orders and	the medication				
	administration records					
		S				
V 436	SPACE AND EQUIPM	s. AENT	14/ 496			
V 436	SPACE AND EQUIPM CFR(s): 483.470(g)(2	AENT	W 436	Wilson Smith Cottage shall turnish, maintai	n 07-01-2025	
V 436	SPACE AND EQUIPM CFR(s): 483.470(g)(2	AENT	W 436	make informed choices about the use of	n 07-01-2025 ind	
/ 436	CFR(s): 483.470(g)(2 The facility must furnis	/ENT) sh, maintain in good repair	W 436	make informed choices about the use of dentures, evenlasses, hearing and other	ind	
V 436	CFR(s): 483.470(g)(2 The facility must furnis	/ENT) sh, maintain in good repair	W 436	make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other	ind	
	CFR(s): 483.470(g)(2 The facility must furnis and teach clients to us	/ENT) sh, maintain in good repair, se and to make informed	W 436	make informed choices about the use of	ind	
	CFR(s): 483.470(g)(2 The facility must furnis and teach clients to us choices about the use	AENT) sh, maintain in good repair, se and to make informed of dentures, eveglasses,		make informed choices about the use of make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devi identified by the IDT as needed by the client in such case as a rocker knife being identified	ces	
	CFR(s): 483.470(g)(2 The facility must furnis and teach clients to us choices about the use hearing and other com	AENT) sh, maintain in good repair, se and to make informed of dentures, eyeglasses, imunications aids, braces		make informed choices about the use of make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devi identified by the IDT as needed by the clien In such case as a rocker knife being identifie as a needed device. Prog Dir/OP will write	ces L ed	
	CFR(s): 483.470(g)(2 The facility must furnis and teach clients to us choices about the use hearing and other com and other devices iden interdisciplinary team a	AENT) sh, maintain in good repair, se and to make informed of dentures, eyeglasses, imunications aids, braces, ntified by the as needed by the client		In good repair, and teach its clients to use a make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devi identified by the IDT as needed by the clien In such case as a rocker knife being identified as a needed device, Prog Dir/QP will write a goal for the indivinal to be implemented by	ces L ed	
	CFR(s): 483.470(g)(2 The facility must furnis and teach clients to us choices about the use hearing and other com and other devices iden interdisciplinary team a	AENT) sh, maintain in good repair, se and to make informed of dentures, eyeglasses, imunications aids, braces, ntified by the as needed by the client		In good repair, and teach its clients to use a make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devi identified by the IDT as needed by the client in such case as a rocker knife being identified as a needed device, Prog Dir/QP will write a goal for the individual to be implemented by staff. The goal shall be SMAPT (coording)	ces L ed	
	CFR(s): 483.470(g)(2 The facility must furnis and teach clients to us choices about the use hearing and other com and other devices iden interdisciplinary team a This STANDARD is no Based on observation	AENT) sh, maintain in good repair. se and to make informed of dentures, eyeglasses, imunications aids, braces, imunications aids, braces, imunications, braces, imunications, aids,		In good repair, and teach its clients to use a make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devidentified by the IDT as needed by the client in such case as a rocker knife being identified as a needed device, Prog Dir/QP will write a goal for the individual to be implemented by staff. The goal shall be SMART (specific, measurable, attainable, relevant and time-based) with interventions supporting the iter.	ces L	
	CFR(s): 483.470(g)(2 The facility must furnis and teach clients to us choices about the use hearing and other com and other devices iden interdisciplinary team a This STANDARD is no Based on observation interviews, the facility f	AENT) sh, maintain in good repair, se and to make informed of dentures, eyeglasses, imunications aids, braces, imunications aids, braces, imunications, aids, aids, aids, aids, aids, aids, aids, aids, aids, aid		In good repair, and teach its clients to use a make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devi identified by the IDT as needed by the clien. In such case as a rocker knife being identified as a needed device, Prog Dir/QP will write a goal for the individual to be implemented by staff. The goal shall be SMART (specific, measurable, attainable, relevant and time-based) with interventions supporting the its achivement. Staff members will downment to the stachivement.	ces L	
	CFR(s): 483.470(g)(2 The facility must furnis and teach clients to us choices about the use hearing and other com and other devices ider interdisciplinary team a This STANDARD is no Based on observation interviews, the facility for prescribed adaptive eq	AENT) sh, maintain in good repair, se and to make informed of dentures, eyeglasses, munications aids, braces, ntified by the as needed by the client, ot met as evidenced by: s, record review and ailed to assure that upment was furnished for		In good repair, and teach its clients to use a make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devi identified by the IDT as needed by the client in such case as a rocker knife being identified as a needed device, Prog Dir/QP will write a goal for the individual to be implemented by staff. The goal shall be SMART (specific, measurable, attainable, relevant and time-based) with interventions supporting the its achivement. Staff members will document the clients daily progress and Prop Dir/QP with the section of the se	ces L	
	CFR(s): 483.470(g)(2 The facility must furnis and teach clients to us choices about the use hearing and other com and other devices ider interdisciplinary team a This STANDARD is no Based on observation interviews, the facility f	AENT) sh, maintain in good repair, se and to make informed of dentures, eyeglasses, munications aids, braces, ntified by the as needed by the client, ot met as evidenced by: s, record review and ailed to assure that upment was furnished for		In good repair, and teach its clients to use a make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devi identified by the IDT as needed by the clien In such case as a rocker knife being identifie as a needed device, Prog Dir/QP will write a goal for the individual to be implemented by staff. The goal shall be SMART (specific, measurable, attainable, relevant and time- based) with interventions supporting the its achivement. Staff members will dowing the its achivement.	ees e	

Event ID: N/H311

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TATEME	NT OF DEFICIENCIES	& MEDICAID SERVICES			FORM APPRO
ND PLAN	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A EUILDI	(X3) DATE SURVEY COMPLETED	
		34G204	6 WING		
NAME O	F PROVIDER OR SUPPLIER		1	STHEET ADDRESS, CITY, STATE, ZIP CODE	05/14/2025
	N SMITH COTTAGE				
11230	N SMITH COTTAGE		1	185 MARTINDALE RD	
(X4) ID	SUMMADY S	TATEMENT OF DEFICIENCIES		WINSTON SALEM, NC 27107	
PREFIX	(EACH DEFICIENC	VERIENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETI COMPLETI E DATE
W 436	6 Continued From page	e 15	W 43	36	
	Observations during	survey 5/13 - 5/14/25			
	revealed client #5 to o	consume the dinner meal			
	breakfast Continued	scept for an egg omelette at			
	#5 was provided with	observations revealed client the following utensils: fork,			
	Spoon and butter knif	e. At no time during the			
	mealtime observation	s was client #5 provided			
	with a rocker knife.	s was chern #5 provided			
	Review of the record of	on 5/14/25 for client #5			
	revealed an individual	habilitation plan (IHP)			
	dated 2/3/25. Review of	of the IHP revealed a			
	cletary evaluation date	d 2/10/25 that revealed			
	that the client has an a	daptive knife that he uses			
	spoon and fork.	e can feed himself with a			
	Interview on 5/13/25 wi	th the qualified intellectual			
	t5's HP was surrent of	(QIDP) verified that client			
	the QIDP revealed that	Continued interview with			
	provided the client with	his proposibad as a			
	knife.	ma prescribed rocker			
448	EVACUATION DRILLS				
	CFR(s): 483.470(i)(2)(iv)		Wilson Smith Cottage will investigate all problems with evacuation drills, including	
1	The facility must investig	ate all problems with		accidents. Evidence of investigations with	ĩ
	evacuation drills, including	no accidents		ucumented on the group homo's Fin	9
-	This STANDARD is not	met as evidenced but		Rehearsal Report. After each fire / evacuation drill, the Program Manager w	
	Based on record review	and interview, the facility		eview the usle, time narticinante	i
í	alled to investigate any	problems with fire drills		vacuation length narrative and choose	
	ncluding the reason for a	extended times for	1	esponse. Upon the assessment if a	1
11	evacuation. The finding i		}	conducted by the Prog Man Investigation	
e				luestions conclusions and investigation	1
e F	Review of facility fire drill	reports revealed the	c	e documented on the report. All Fire	vill
ii e Fi	Review of facility fire drill ollowing dates that excer /01/25-10 minutes, 2/12	reports revealed the eded five minutes:	c b F	uestions, conclusions, and corrections we be documented on the report. All Fire Rehearsal reports will be signed by the Pi tan as evidence of review.	vill

Event ID NH311

Facility ID 021933

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ATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES			FORM APPRO OMB NO. 0938-	
ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		34G204	U WING			
IAME OF I	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE	05/14/2025	
VILSON	SMITH COTTAGE		1	185 MARTINDALE RD		
				WINSTON SALEM, NC 27107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S FLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CRUSS-REFERENCED TO THE APPROP DEFICIENCY)	DAF	
W 448	Continued From pag	je 16	14/ 4	0		
		and, 9/16/24-6 minutes.	W 44	6		
	Interview with the qu	alified intellectual disabilities				
	protessional (QIDP)	on 5/14/25 revealed the				
	lacility fire drill form h	ad been updated but did not				
	include a section for exten	staff to provide an ded evacuation times.				
	Continued interview	with the QIDP revealed the				
	update fire drill form a	also did not include a section				
	to record the total nur	nber of clients and staff				
	participating in the dri					
463	FOOD AND NUTRITI	ON SERVICES	W 463	Milese D. III. C.		
	CFR(s): 483.480(a)(4)		Wilson Smith Cottage IDT, shall include fied dietitian and physician shall prescrit modified and service shall prescrit	a quali- 07-01-2	
	The align the interview			modified and special diets. The Present	be all	
	The client's interdiscip	linary team, including a				
r	modified and special d	physician must prescribe all		meetings to allow for consultative review progress update discussions. Prog Dir/C		
7	This STANDARD is n	ot met as evidenced by:		Chigu C fild inere is a noveleign'e order i		
1	Based on observation	record review and		special diets to include but not limited to dietary supplement. The Prog Dir/QP will that the consultant direct di		
11	nterview, the facility fa	iled to ensure 1 of 5				
a	udited clients (#5) rec	eived their specialty diet as			arterly	
p	rescribed. The finding	is:		progress. The Prog Director will ensure the training of direct care staffs of individ	uale'	
~				SPECIAL VIELALV DEPENS OF LOOST DOOLULIN. P		
P	M revealed align the grou	up home on 5/13/25 at 4:32		n-person meal observations no loss the	tine	
'n	Real which consisted a	o participate in the dinner		HUDIEIN, UCCUMENTATION OF SUCH above		
nu	uggets, roll, and juice	f lima beans, fried chicken Continued observations		will be maintained. Prog Manager will cor periodic impromptu checks during meals		
re	vealed client #5 to co	nsume the dinner meal		ansure diet adherence.	to	
ar	to exit the cining area	. At no time during the		Sec. Consider March 201		
05	servations were staff	observed to provide the				
cli	ent with his prescribed	o supplement.				
Ot	servation in the group	o home on 5/14/25 at 7:16				
AN	A revealed client #5 to	participate in the				
DIE	relette juice and all	nsisted of oatmeal, egg				
rev	realed client #5 to con	. Continued observations sume the breakfast mea!				
witi	hout eating the end or	sume the breakfast mea! nelette. At no time during				
	2 39 01	mene. Al no une dunha			1	

FOR!

Event ID N H311

Facility ID 921993

If continuation sheet Page 17 of 18

STATEMENT	T OF DEFICIENCIES	MEDICAID SERVICES			PRINTED: 05 FORM API OMB NO. 09
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X3) DATE SURV COMPLETED
NAME OF I	PROVIDER OR SUPPLIER	34G204	5 WING		
				STREET ADDRESS, CITY, STATE	ZIP CODE 05/14/20
WILSON	SMITH COTTAGE			185 MARTINDALE RD	
(X4) ID	SUMMARY S	ATEMENT OF DEFICIENCIES		WINSTON SALEM, NC 2710	
PREFIX TAG	LEACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	N OF CORRECTION COMP EACTION SHOULD BE COMP D TO THE APPROPRIATE DO DENCY)
W 463	Continued From page	17			
	the observations were	staff observed to provide	W 46	53	
	the client with his pre-	scribea supplement			
	Review of records on	5/14/25 for clien: #5			
	revealed a dietary eva	luation dated 2/10/25			
	Continued review of th	e dietary evaluation			
	with two supplements	is prescribed a regular diet			
	calories. The client's si	upplement is Ovalting			
1	mixed with whole milk.				
I	Interview on 5/14/25 w	th the qualified intellectual			
C	isabilities professiona	(QIDP) confirmed clippt			
1	he QIDP confirmed that	Continued interview with			
p	provided client #5 with	his prescribed diet which			
11	ncludes the supplement	t Ovalline.			

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