STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G116	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST MAIN STREET FACILITY-CARRBORO	**1003 W MAIN STREET CARRBORO, NC 27510**

(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 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the nurse failed to ensure that health complaints were evaluated and treated for 1 of 4 audit clients (#5). The finding is: Record review on 5/28/25 revealed a 3/11/25 T-log note where client #5 complained of right foot/big toe pain and it appeared her toenails needed to be cut. On 5/1/25, client #5 was given ice to apply to her right foot after complaining of pain. On 5/2/25, client #5 reported she stubbed her toe on the sidewalk and complained of foot pain. On 5/7/25, client #5 saw a doctor after a fall and was sent to the emergency department. The scans were taken of her head, cervical spine and right wrist, but her foot was not examined. Her pain was treated with a medication. The interview on 5/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the nurse "probably should have" made a recommendation of how to handle client #5's complaints of foot pain, after reviewing the T-logs on 3/12/25 and 5/2/25.	W 331		
W 348	DENTAL SERVICES CFR(s): 483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.	W 348		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G116	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST MAIN STREET FACILITY-CARRBORO	1003 W MAIN STREET CARRBORO, NC 27510

(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 348	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that recommended dental treatment was performed. This affected 1 of 4 audit clients (#1). The finding is: Record review on 5/28/25 revealed client #1's last dental exam was on 8/22/24 and it was noted that one of his fillings had fallen out. The dentist recommended at the next exam, (timeframe was not determined) will examine if oral surgery is needed. There was no documentation that client #1 had a follow-up dental exam. Interview on 5/28/25 with the Home Manager, she acknowledged that she reviewed the 8/22/24 dental exam recommendations for client #1 but had forgotten to schedule a follow-up exam. An interview on 5/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #1 sees a different dentist than the other clients in the home, however she could not find any evidence that he received any more dental treatment.	W 348		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to perform fire drills at least each quarter for each shift. The finding is: Record review on 5/28/25 of the facility's fire drills revealed the following dates they were conducted:	W 440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G116	A. BUILDING _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST MAIN STREET FACILITY-CARRBORO	**1003 W MAIN STREET CARRBORO, NC 27510**

(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 440	Continued From page 2 On 5/23/24 at 9:17am, 7/18/24 at 5:30pm, 9/6/24 at 7:45PM, 10/9/24 at4:50PM and 11/16/24 at 1:15AM. In 2025, fire drills were conducted on 2/5/25 at 11:30PM and 4/11/25 at 8:00 pm. The interview on 5/28/25 with the Home Manager revealed they received internal audits from their corporation and passed; therefore, she was not aware there were any problems with the fire drills.	W 440		