DEPART	-	APPROVED								
		& MEDICAID SERVICES			0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		34G144	B. WING			06/18/2025				
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
WILDCAT GROUP HOME					208 WILDCAT ROAD					
WILDOA			DEEP GAP, NC 28618							
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTIO	N (X5)				
PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI		(EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE			
TAG			TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	CIATE DATE				
	1		1							
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)		W 1	W 125						
		sure the rights of all clients.								
		ity must allow and encourage								
		exercise their rights as clients								
		is citizens of the United States,								
		o file complaints, and the right								
	to due process.	a not mot as avidopood by:								
		s not met as evidenced by: tions and interviews, the facility								
	failed to ensure clients (#4, #13 and #15) had the right to be treated with dignity regarding the use									
		Iding. The finding is:								
	of moontmonoe peaking. The maing is.									
	During observations in the home on 6/17/25 from 4:00pm to 6:00pm, clients #4, #13 and #15 were									
	observed sitting on incontinence pads in the living									
	room recliners (#4 and #13) and their personal									
	wheelchair (#15).									
	Interview on 6/18/25 with Staff A revealed the incontinence pads are used to protect the									
		of the wheelchair due to								
	toileting accidents.									
	5									
		5 with the qualified intellectual								
		onal (QIDP) revealed the								
		are used to protect the								
		of the wheelchair due to								
	5	The QIDP confirmed this is a								
	dignity issue for the									
W 436			W 4	-36						
	CFR(s): 483.470(g))(∠)								
	The facility must fur	rnish maintain in good ronair								
		rnish, maintain in good repair, o use and to make informed								
		ise of dentures, eyeglasses,								
		communications aids, braces,								
	and other devices in									
		,								

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

TITLE

(X6) DATE

PRINTED: 06/19/2025

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.

DEPAR ⁻ CENTEI	RINTED: 06/19/2025 FORM APPROVED MB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G144	B. WING			06/ [,]	18/2025
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WILDCAT GROUP HOME					08 WILDCAT ROAD DEEP GAP, NC 28618		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 436	GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #15 was taught to use and make informed choices about the use of her foot booties and eyeglasses. This affected 1 of 5 audit clients. The finding is: During observations in the home throughout the survey on 6/17/25 - 6/18/25, client #15 was observed to not wear eyeglasses. Additionally, observations revealed client #15 to not have on foot booties during observations in the home on 6/17/25. Review on 6/18/25 of client #15's occupational therapy evaluation 6/20/24 revealed client #15 wears eyeglasses. Review on 6/18/25 of client #15's physical therapy evaluation dated 3/19/25 revealed client #15 wears soft booties on both feet. Interview on 6/18/25 with client #15 revealed she is supposed to wear her foot booties day and night. Continued interview with client #15 revealed the foot booties help prevent her feet from developing blood blisters. Interview on 6/18/25 with the qualified intellectual disabilities professional (QIDP) confirmed client #15 is supposed to wear soft booties on both feet at all times, and should be wearing eyeglasses, Continued interview with the QIDP revealed client #15 will refuse the soft booties and eyeglasses, but confirmed staff should periodically prompt client #15 to wear them.		W 4	136	· · · · ·		

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

Facility ID: 922879

If continuation sheet Page 2 of 2