STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G308	A. BUILDING _____ B. WING _____	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHCROFT	3046 HEATHCROFT COURT CHARLOTTE, NC 28269

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure the rights of dignity for 1 of 6 clients (#5) in relation to the use of incontinence padding. The finding is: Observations in the group home 6/16-6/17/25 at 5:36 revealed an incontinence pad visibly in client #5's personal chair located in the client's bedroom. Continued observation revealed that client #5's chair was the only chair in the home with an incontinence pad placed in the chair. Interview on 6/17/25 with the qualified intellectual disabilities professional (QIDP)) revealed that an incontinence pad was placed in client #5's personal chair to prevent a toilet incident in the chair. Continued interview with the QIDP verified that an incontinence pad should not have been placed in the client's chair.	W 125		
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.	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER 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.

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W 249	Continued From page 1	W 249		

This STANDARD is not met as evidenced by:
Based on observation, interviews, and record review, the facility failed to assure a continuous active treatment program identified as an individual need was implemented for 2 of 6 clients (#2 and #3) relative to adaptive equipment. The findings are:

A. The facility failed to implement prescribed adaptive equipment for client #2. For example,

Observations in the group home 6/17/25 at 7:11 AM revealed client #2 to consume the breakfast meal. Continued observations revealed client #2 to eat the breakfast meal with a sectional plate and a curved white handle spoon. Further observations revealed that client #2 moved the spoon over her toast and did not appear to be able to maneuver the curved white handle spoon. Subsequent observations revealed that the client is prescribed a sectional adaptive plate and a built-up spoon. At no time during mealtime observations was client #2 provided with the prescribed built-up spoon.

Review of the records on 6/17/25 for client #2 revealed an individual support plan (ISP) dated 6/12/25. Continued review of the ISP revealed a nutritional assessment dated 5/5/25 for client #2's adaptive equipment to consist of an adaptive sectional plate and a built-up spoon.

Interview on 6/17/25 with the qualified intellectual disabilities professional (QIDP) verified that client #2's ISP was current. Continued interview with the QIDP revealed that the staff should have

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W 249	Continued From page 2 provided client #2 with prescribed adaptive equipment. B. The facility failed to implement prescribed adaptive equipment for client #3. For example, Observations during survey 6/16-6/17/24 revealed client #3 to consume a portion of the dinner meal and breakfast meal. Continued observations revealed client #3 to eat the dinner with the following adaptive equipment to include a divided dish and built -up spoon, built-up knife and a built-up fork. Further observations revealed the client to eat the breakfast meal with a shirt protector, built spoon, and built knife, and divided dish. Further observations revealed that client #3 is prescribed a Coated/weighted spoon (all meals) and a rimmed/lipped plate. At no time during mealtime observations was client #2 provided with the prescribed Coated/weighted spoon and rimmed/lipped plate. Review of the record on 6/17/25 for client #3 revealed an ISP dated 2/18/25. Review of the ISP revealed a nutritional assessment dated 5/5/25 for client #3's adaptive equipment to consist of a Coated/weighted spoon (all meals) and a rimmed/lipped plate. Interview on 6/517/25 with the QIDP verified that client #3's ISP was current. Continued interview with the QIDP revealed that the staff should have provided client #3 with her prescribed adaptive equipment.	W 249		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals	W 382		

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W 382	Continued From page 3	W 382		

locked except when being prepared for administration.
This STANDARD is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure all prescribed medications were secured appropriately as required for 6 of 6 clients. The finding is:

Observation in the group home 6/17/25 at 6:19 AM revealed staff C to notify the triage nurse to receive permission to administer client #4 PRN pain medication. Continued observation revealed staff C looked in the top medication administration cabinet and the lower metal drawer cabinet storage area with no PRN Tylenol medication located. Continued observations revealed staff C to call out to staff A to assist with locating PRN Tylenol for client #4. Further observations revealed staff A called out to staff E to locate the PRN Tylenol.

Subsequent observations revealed staff E to walk from the back of the home and bring a bag containing several boxes of PRN medications including Tylenol. Additionally, staff A handed staff C a brand-new box of Tylenol and all remaining boxes of medications were placed in an unlocked cabinet located above the fax machine. At no time during observations was staff observed to secure the cabinet above the fax machine that contained several boxes of medications and bubble packages of medications.

Interview on 6/17/25 with the facility nurse confirmed that the cabinet located above the fax machine should not have prescribed medications stored. Continued interview with the facility nurse confirmed that all medications should always be kept in a locked and secured area unless the

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W 382	Continued From page 4 medication is being administered to clients.	W 382		