PRINTED: 06/23/2025 FORM APPROVED

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY MPLETED
		34G062	B. WING			242422
	PROVIDER OR SUPPLIER DD ACRES		3	STREET ADDRESS, CITY, STATE, ZIP CODE 4464 US HWY 601 SOUTH MOCKSVILLE, NC 27028		06/18/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	CFR(s): 483.475(a) §403.748(a), §416.54 §441.184(a), §460.84 §483.475(a), §484.10 §485.542(a), §485.62 §485.920(a), §486.36 §494.62(a). The [facility] must cor Federal, State and loo preparedness require develop establish and emergency preparedr requirements of this s preparedness prograr limited to, the followin (a) Emergency Plan, and maintain an emer that must be [reviewed every 2 years. The pl following: * [For hospitals at §48 §485.625(a):] Emerge CAH] must comply wit State, and local emerg requirements. The [ho develop and maintain emergency preparedn requirements of this se all-hazards approach. * [For LTC Facilities at Plan. The LTC facility i	A(a), §482.15(a), §483.73(a), 92(a), §485.68(a), 925(a), §485.727(a), 90(a), §491.12(a), 90(a), §491.12(a), 90(a), §491.12(a), 90(a), §491.12(a), 90(a), §491.12(a), 90(a), 90(a)	E 004	DEFICIENCY)	I ensure home rill . The igh x a ind then ie EPP staff. In sional	8/18/25
BORANORYDI	reviewed, and updated	at least annually. JPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

IDD Regional Administrator 6/24/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER OD ACRES			STREET ADDRESS, CITY, STATE, ZIP CODE 3464 US HWY 601 SOUTH MOCKSVILLE, NC 27028		06	/18/2025
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E 004	* [For ESRD Facilitie Plan. The ESRD faci maintain an emergen	s at §494.62(a):] Emergency	E 0	04			
	Based on record revi failed to ensure that to	not met as evidenced by: lew and interview, the facility he emergency preparedness wed and updated at least we to client specific ng is:					
	revealed an EPP date the facility EPP did no specific information fo Continued review of the	umentation on 6/18/25 and 4/25/25. Further review of at reveal evidence of client ar two clients (#1, #4). The facility EPP contained are to two clients who have					
E 039	professional (QIDP) of specific information shadmissions and dischainterview with the QID information for client # added to the facility EF admission to the facilit EP Testing Requireme CFR(s): 483.475(d)(2) §416.54(d)(2), §448.15 §483.475(d)(2), §484.15 §485.542(d)(2), §485.6	P revealed client specific 1 and #4 should have been PP in a timely manner after y. nts 13(d)(2), §441.184(d)(2),	E 039				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER DD ACRES		3	STREET ADDRESS, CITY, STATE, ZIP CODE 464 US HWY 601 SOUTH MOCKSVILLE, NC 27028	06/18/2025
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
	at §485.542, OPO, §485.727, CMHCs a §491.12, and ESRD (2) Testing. The [facto test the emergence must do all of the following of the following of the following of the following of the facility natural or man-made activation of the emergence exempt from engaging community-based or functional exercise for actual event. (ii) Conduct an additing of the following o	2.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]: cility] must conduct exercises by plan annually. The [facility] Illowing: Ill-scale exercise that is every 2 years; or nity-based exercise is not a facility-based functional ars; or emergency that requires ergency plan, the [facility] is ng in its next required individual, facility-based collowing the onset of the ional exercise at least every 2 ever the full-scale or nder paragraph (d)(2)(i) of cted, that may include, but is owing: le exercise that is individual, facility-based or drill; or se or workshop that is led by des a group discussion using	E 039	The Qualified Professional and Safety Chairperson will update to Emergency Preparedness Plan. Qualified Professional will train a staff on the plan. The Regional Administrator will monitor the Emergency Preparedness Plan 6 months to ensure it remains updated and staff are trained. The Program Manager and Safety Chairperson will organize and complete a tabletop exercise. The Safety Chairperson will monitor to ensure tabletop exercises are completed at least on an annual basis. In the future, the Regional Administrator will ensure tabletop exercises are completed on an annual basis. The Qualified Professional will ensure the Emergency Preparedness Plan is updated and staff are trained on current plan and training conduct annually.	The all every ne sethe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G062	B. WING			6/49/2025
	PROVIDER OR SUPPLIER DD ACRES		3464	EET ADDRESS, CITY, STATE, ZIP CODE US HWY 601 SOUTH CKSVILLE, NC 27028		6/18/2025
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	exercises, and emerge [facility's] emergency *[For Hospices at 418 (2) Testing for hospic patient's home. The lexercises to test the eannually. The hospic (i) Participate in a full community based every (A) When a community accessible, conduct a functional exercise every (B) If the hospice experimental emergency plan, the e	ion of all drills, tabletop plan, as needed. 3.113(d):] les that provide care in the plan, as needed. 3.113(d):] les that provide care in the plan as needed. 3.113(d):] les that provide care in the plan as needed. 3.113(d):] les that provide care in the plan as needed. 3.113(d):] les that provide care in the plan as needed. 3.113(d):] les that provide care in the plan as needed. 3.113(d):] les that provide care in the plan as needed. 3.113(d):] les that provide care in the plan as needed. 3.113(d):] les that provide care in the plan as teast each tis priences that is exempt from plan as needed. 3.113(d):] les that provide care in the plan as needed. 3.113(d):] les that provide care in the plan as needed. 3.113(d):] les that provide care in the plan as needed. 3.113(d):] les that provide care in the plan as teast priences a natural or priences anatural or priences anatura	E 039			

STATEMENT	OF DEFICIENCIES	(NA) PROUE CENTUCES			OMB	NO. 0938-0391
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	PROVIDER OR SUPPLIER DD ACRES			STREET ADDRESS, CITY, STATE, ZIP CO 3464 US HWY 601 SOUTH MOCKSVILLE, NC 27028	DE	3.1.0/2020
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	care directly. The hose exercises to test the exercises in an anis community-based; (A) When a community accessible, conduct an facility-based functions. (B) If the hospice experimental exercises and the emergency plan, the emergency problem is the emergency of the emergency plan, the emergency plan and a set of problem is the emergency plan and a set of problem is the emergency plan and a set of problem is the emergency plan and a set of problem is the emergency plan and t	spice must conduct emergency plan twice per ust do the following: nnual full-scale exercise that or y-based exercise is not n annual individual al exercise; or eriences a natural or y that requires activation of the hospice is exempt from quired full-scale community if functional exercise the emergency event. onal annual exercise that it limited to the following: the exercise that is facility based functional rill; or the or workshop led by a a group discussion using a vant emergency scenario, tatements, directed disquestions designed to to y plan. the plan, as needed. 34(d), Hospitals at 485.625(d):] Hospital, CAH] must	E 03			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION NO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED
		34G062	B. WING _			06/18/2025
	PROVIDER OR SUPPLIER DD ACRES			STREET ADDRESS, CITY, STATE, ZIP COD 3464 US HWY 601 SOUTH MOCKSVILLE, NC 27028	E	00/10/2023
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E 039	is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the [PRTF, Hos actual natural or mannequires activation of [facility] is exempt from required full-scale confacility-based function onset of the emergence (ii) Conduct an [a and that may include, following: (A) A second full-scale community-based or infunctional exercise; or (B) A mock of (C) A tabletop excelled by a facilitator and discussion, using a nate mergency scenario, a statements, directed in questions designed to plan. (iii) Analyze the [final maintain documentation exercises, and emergency in the pack of (2) Testing. The PACE exercises to test the eannually. The PACE of following:	innual full-scale exercise that or ty-based exercise is not an annual individual, hal exercise; or pital, CAH] experiences an -made emergency that the emergency plan, the mengaging in its next inmunity based or individual, hal exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based control includes a group arrated, clinically-relevant and a set of problem incessages, or prepared in challenge an emergency ency events and revise the plan, as needed. 4(d):] i organization must conduct intergency plan at least rganization must do the innual full-scale exercise that interpretation in the innual full-scale exercise that in the innual full-scale exercise in the inn	E OS	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	(A) When a communication accessible, conduct a facility-based function (B) If the PACE experiment accessible, conduct a facility-based function (B) If the PACE experiment accessible, conduct and the emergency plan, engaging in its next rebased or individual, factorise following the event. (ii) Conduct an accession accession (iii) Conduct an accession ac	ity-based exercise is not an annual individual, hal exercise; or riences an actual natural or by that requires activation of the PACE is exempt from equired full-scale community acility-based functional exposed on the emergency diditional exercise every 2 are the full-scale or functional raph (d)(2)(i) of this section of include, but is not limited to de exercise that is notividual, a facility based of individual, a facility based of the emergency problem statements, and emergency problem statements, and emergency plan. E's response to and for of all drills, tabletop ency events and revise the fan, as needed. §483.73(d):] The full-scale exercise that is not limited to be an at least twice per year, distaff drills using the state of the control o	E 039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTA. BUILDI		DISTRUCTION	(X3) DATE SURVEY COMPLETED	391
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BOXWOO	ROVIDER OR SUPPLIER D ACRES			3464	EET ADDRESS, CITY, STATE, ZIP CODE US HWY 601 SOUTH CKSVILLE, NC 27028	00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI; TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC	NC
E 039	accessible, conduct a facility-based functio (B) If the [LTC facility actual natural or mar requires activation of LTC facility is exemp required a full-scale of individual, facility-based following the onset of (ii) Conduct an addit may include, but is not (A) A second full-scale community-based or functional exercise; of (B) A mock disaster (C) A tabletop exercial facilitator includes a narrated, clinically-reland a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerge (ITC facility] facility's at §483 (2) Testing. The ICF/IID sat §483 (2) Testing. The ICF/IID must do (i) Participate in an aris community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID expedition of the community accessible, conduct a facility-based function (B) If the ICF/IID expeditions.	ity-based exercise is not an annual individual, nal exercise. I facility experiences an in-made emergency that the emergency plan, the trom engaging its next community-based or sed functional exercise if the emergency event. It ional annual exercise that the emergency event. It is individual, facility based or sed functional exercise that is an individual, facility based or dirill; or se or workshop that is led by a group discussion, using a evant emergency scenario, statements, directed ed questions designed to incur plan. If facility] facility's response to entation of all drills, tabletop tency events, and revise the emergency plan, as needed. 3.475(d)]: ID must conduct exercises or plan at least twice per year, the following: innual full-scale exercise that or ty-based exercise is not in annual individual,	E	039			

STATEMENT	OF DEFINITIONS	WEDICAID CERVICES			OMB	NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY MPLETED
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NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE .	00/10/2023
BOXWOO	DD ACRES			3464 US HWY 601 SOUTH		
				MOCKSVILLE, NC 27028		
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E 039	the emergency plan, engaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an additionary include, but is not (A) A second full-scal community-based or functional exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and includusing a narrated, cliniscenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/II maintain documentative exercises, and emergic ICF/IID's emergency processes and emergency plast annually. The HH to test the emergency least annually. The HH to test the emergency least annually. The HH to test the emergency least annually.	the ICF/IID is exempt from equired full-scale individual, facility-based illowing the onset of the onal annual exercise that of limited to the following: e exercise that is an individual, facility-based rill; or se or workshop that is led by les a group discussion, cally-relevant emergency for problem statements, reprepared questions e an emergency plan. D's response to and on of all drills, tabletop ency events, and revise the olan, as needed.	EO			
	accessible, conduct ar	nunity-based exercise is not				
	(B) If the HHA ex or man-made emerger of the emergency plan engaging in its next re- community-based or ir	periences an actual natural ncy that requires activation to the HHA is exempt from quired full-scale ndividual, facility based owing the onset of the				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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E 039	emergency event. (ii) Conduct an add opposite the year the exercise under particles and composite the year the exercise under particles and composite the year the exercise under particles and community-based functional exercise (B) A mock discussion, using a emergency scenaric statements, directle questions designed plan. (iii) Analyze the High documentation of a emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The to test the emergency events are the emergency scenaric statements, directle questions designed plan. If the OPO exeman-made emergency plan engaging in its next exercise under the emergency plan engaging in its next exercise under the emergency plan engaging in its next exercise under the emergency plan engaging in its next exercise under the emergency plan engaging in its next exercise under the emergency plan engaging in its next exercise under the emergency plan engaging in its next exercise under the emergency plan engaging in its next exercise under the emergency plan engaging in its next exercise under the emergency event.	litional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section hat may include, but is not ving: ull-scale exercise that is or an individual, facility-based; or exercise or workshop that is and includes a group a narrated, clinically-relevant to, and a set of problem d messages, or prepared at to challenge an emergency IA's response to and maintain Il drills, tabletop exercises, and and revise the HHA's s needed.	E 039			

		WEDIOAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	(ii) Analyze the OPO documentation of all	's response to and maintain tabletop exercises, and and revise the [RNHCI's and olan, as needed.	E 039		
	(d)(2) Testing. The R exercises to test the must do the following (i) Conduct a paper-t least annually. A tabl discussion led by a facilinically-relevant emof problem statement prepared questions demergency plan. (ii) Analyze the RNH0 maintain documentat and emergency even emergency plan, as r This STANDARD is Based on record rev facility failed to show	NHCI must conduct emergency plan. The RNHCI g: pased, tabletop exercise at etop exercise is a group acilitator, using a narrated, ergency scenario, and a set ts, directed messages, or lesigned to challenge an CI's response to and ion of all tabletop exercises, ts, and revise the RNHCI's needed. not met as evidenced by: iew and interviews, the evidence of exercises to mergency preparedness			
	revealed an EPP date the facility's EPP did mock drill, tabletop ex	umentation on 6/18/25 ed 4/25/25. Further review of not reveal evidence of a kercise, or full-scale ercise to test the facility's			
	professional (QIDP) of evidence of a tableton full-scale exercise con	alified intellectual disabilities on 6/18/25 revealed that of exercise, mock drill, or all uld not be found during the liew with the QIDP revealed assed, however, the			

CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 039	documentation could interview with the QII management should preparedness exercise required.	not be found. Continued DP verified that staff and complete all emergency ses to test the EPP as	E 039		
W 104	CFR(s): 483.410(a)(1) The governing body budget, and operating This STANDARD is Based on observation interviews, the govern failed to exercise ger direction over the fact facility repairs were consisted in the graph of the following items on the chair, two 5-foot plast portable standing towel standing towel standing towel standing towel standing towel of the following items on the chair, two 5-foot plast portable standing towel standing towel standing towel standing towel standing towel standing towel of the following items to be picked up orders revealed no ordiscarded. Interview with staff A have made management to be picked up completed any work of the following items or the	must exercise general policy, g direction over the facility. not met as evidenced by: en, record review and ning body and management deral policy and operating ility by failing to assure conducted timely. The finding group home during the 17/25 - 6/18/25 revealed the expatio: a broken wooden tic LED light covers, a let seat and metal free a Continued observations work orders submitted for the form of the facility's work orders for the items to be sent aware of the items that but they have not	W 104	W104 The business manager will in-sent the maintenance coordinator on completing work orders in a timely manner. The clinical team will mothrough environmental assessme 2x a week for a period of 30 days then on a routine basis to ensure work orders are completed. In the future, the maintenance coordinate will ensure all work orders are completed in a timely manner.	y nitor nts and all

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		34G062	B. WING		06/1	8/2025
NAME OF PROVIDER OR SUPPLIER BOXWOOD ACRES		3	TREET ADDRESS, CITY, STATE, ZIP CODE 464 US HWY 601 SOUTH IOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 104	Further interview the should be placing ord hauled away. PROTECTION OF CI CFR(s): 483.420(a)(3) The facility must ensure the facility individual clients to expect of the facility, and as including the right to five due process. This STANDARD is represented by the facility audited clients (#1) excitizens relative to dignostrative to dignostra	at need to be picked up. QIDP revealed management ders for the items to be LIENTS RIGHTS are the rights of all clients. Items and encourage dercise their rights as clients citizens of the United States, file complaints, and the right and met as evidenced by: In, record reviews and failed to ensure 1 of 6 dercise rights as clients and nity. The finding is: In en 6/18/25 at 7:25 AM staff G to instruct her to aced a green pad on the her; then instructed her to osition. Continued #1 revealed her to indicate ther observation for client instruct her to go to the ent observation of client #1 to the living room and that she felt better from her 6/18/25 for client #1 intered plan (PCP) dated review of client 1's PCP in trash out, replace bag and	W 104	W125 The qualified professional will implement a toileting program for client #1 and will in-service all starthe new program. The clinical tear will monitor through interaction assessments 1x a week for a periof 30 days and then on a routine basis to ensure the new toileting program is followed. In the future, qualified professional will ensure programs are created for identified areas of need.	ff on m od the	8/18/25

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		34G062	B. WING			06/18/2025
NAME OF PROVIDER OR SUPPLIER BOXWOOD ACRES			STREET ADDRESS, CITY, STATE, ZIP 3464 US HWY 601 SOUTH MOCKSVILLE, NC 27028	CODE	0,10,2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 125	Continued From page 13 behavior support plan dated 4/2/24 with target behaviors of physical aggression, verbal aggression, refusal, property destruction, leave area without notice - (LAWN), food obsession, nudity, fecal smearing, pacing and parnola. Interview on 6/18/25 with the qualified intellectual disabilities professional (QIDP) confirmed that		W 1	125		
	client #1 can let staff the restroom. Contin revealed two words the indicate when she ne movement or urinate. listed strategies staff reinforcement proced communication with he Subsequent interview client #1 would benef objective focused on strategies.	know when they need to use used interview with the QIDP nat staff and client #1 use to eds to have a bowel Further review of the BSP could use for preventive and ures to further foster her toileting success. with the QIDP confirmed it from a new learning the use of her behavioral				
W 129	551.00018500-03.0010		W 1	29		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G062	B. WING		06/18/2025	
NAME OF PROVIDER OR SUPPLIER BOXWOOD ACRES			3	TREET ADDRESS, CITY, STATE, ZIP CODE 464 US HWY 601 SOUTH IOCKSVILLE, NC 27028	00/10/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
W 129	Continued From page 14 7:12AM revealed staff to transfer client #4 from his room to the bathroom without any pants. Additional observation at 7:19AM revealed staff to exit the bathroom door leaving client #4 exposed and toileting with the door open. Subsequent observations at 7:30AM revealed the video monitor to remain on while client #4 was receiving personal care in his room. At no point during the observations did staff ensure client #4 received privacy during personal care. Interview with the qualified intellectual disabilities professional (QIDP) on 6/18/25 verified that the video monitor for client #4 should be turned off during awake hours. Further interview with the QIDP revealed the video monitor is to be used at night due to the client's seizure disorder diagnosis. Continued interview with the QIDP revealed staff have been trained on respecting clients' privacy during personal care. 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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that a		W 129	The qualified professional will in-service all staff on the use of virmonitors and ensuring the privacy People Supported. The clinical teawill monitor through interaction assessments 1x a week for a periof 30 days and then on a routine basis to ensure video monitors are used as ordered. In the future, the qualified professional will ensure a staff are trained on the use of vide monitors.	of am od	
	interviews, the facility					

STATEMENT	OF DEFICIENCIES	OUL FROM THE SERVICES			OMB N	IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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W 249	of needed behavioral implemented as ident plan (PCP) for 1 of 3 a finding is: Observations through from 6/17/25 - 6/18/25 attempt to communica Portuguese language, revealed client #1 to pactivities to include me administration, person activities while attempt various staff. Continu client #1 to become agto staff and surveyors Portuguese. At no poldid staff provide client device to assist with the English. Review of the record for revealed a PCP dated support plan dated 1/1 should be aware the cobarrier. Further review indicated client #1 become yell/scream/repetishe feels she is not be Additional review of the staff should offer client communicate with the that does not always he confusion or agitation."	interventions were ified in the person-centered audited clients (#1). The out the recertification survey be revealed client #1 to ate with staff speaking in the c. Further observations realtimes, medication all care, chores, and other ting to communicate with ed observations revealed gitated and raise her voice while communicating in int during the observation #1 with a digital translation anslation from Portuguese or client #1 on 6/18/25 12/17/24 and behavior 0/25 which indicated staff lient has a language of the 1/2025 BSP omes easily frustrated and titively say a phrase when ing heard or understood. e 1/10/2025 BSP indicated if 1 a digital translator to client more effectively, "but elp and can cause more ified intellectual disabilities a 6/18/25 revealed staff	W 249	The behavior analyst will in-serv staff on the behavior support pla client #1. The clinical team will me through interaction assessments week for a period of 30 days and on a routine basis to ensure the followed as written. In the future, behavior analyst will ensure all stare trained on the BSPs of Peopl Supported.	n for nonitor 2x a then BSP is the	8/18/25

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PREFIX (EACH DEFICIENT	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
Further interview with #1 has a communicate short phrases to use between staff and the with the QIDP reveal provided the communicated in client #1 W 436 SPACE AND EQUIP CFR(s): 483.470(g)(3) The facility must furnand teach clients to use choices about the use hearing and other conducted and other devices identerdisciplinary team. This STANDARD is Based on observation interviews, the facility adaptive equipment of 6 audited client (#3 finding is: Afternoon observation revealed client #3 to table to prepare for the observations revealed the dinner meal using equipment: shirt protections was client #3 provided the dinner meal. Morning observations.	the translation device. In the QIDP verified that client ation book with keywords and to improve communication e client. Continued interview led staff should have nication interventions as 's BSP as prescribed. MENT 2) Itish, maintain in good repair, use and to make informed the of dentures, eyeglasses, ammunications aids, braces, entified by the in as needed by the client. Into the most as evidenced by: It is not met as eviden	W 436	W436 The qualified professional will in-service all staff on the adaptive equipment of People Supported. clinical team will monitor through meal time assessments 1x a wee for a period of 30 days and then routine basis to ensure adaptive equipment is being utilized as ordered. In the future, the qualified professional will ensure all staff at trained on adaptive equipment.	The ek on a	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(2/0) 1		OMB NO. 0938-0391	
(**) THE VIDEOUT FILL OCT		IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G062	B. WING		06/18/2025	
	PROVIDER OR SUPPLIER DD ACRES		3	STREET ADDRESS, CITY, STATE, ZIP CODE 4464 US HWY 601 SOUTH MOCKSVILLE, NC 27028	00/10/2023	
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W 474	Review of the record revealed a physician indicated the client hequipment to be used spoon, straw (PRN), dish, and shirt protect Interview with the quaprofessional (QIDP) of should have been produring mealtimes. Intervealed staff have been produring mealtimes. Intervealed staff have been produced staff have been produce	for client #3 on 6/18/25 's order dated 6/11/25 which as the following adaptive d during mealtimes: maroon non-skid mat, high sided stor. alified intellectual disabilities on 6/18/25 verified client #3 ovided a maroon spoon terview with the QIDP een trained to provide client ipment as prescribed. (2)(iii) In a form consistent with the of the client. not met as evidenced by: n, record review, and failed to ensure food was sistent with the for 2 of 6 audit clients (#4 are: a assure food was served in for client #4. prescribed. For In the home on 6/18/24 at as observed eating breakfast small muffin, 6 oz yogurt, 1/4 as, 8 oz orange juice, 8 oz The small muffin served in eating all in that form.	W 474	W474 A & B. The qualified professional vin-service all staff on the prescribe diets of People Supported. The clir team will monitor through meal time assessments 1x a week for a period 30 days and then on a routine basinensure prescribed diets are being followed as ordered. In the future, qualified professional will ensure a staff are trained on the prescribed diets.	d nical e od of is to	

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W 474	order consisting of ½ B. The facility failed the right consistency example: During observations 5:00 PM, client #6 w divided plate which of the following: 3 oz potato salad, ½ cup and 8 oz - milk. Conficient #6's dish to ha mixed in with his gro observation revealed and beverages but s containing some grout o ground consistence. Review on 6/18/25 or (PO) dated 6/18/25 r consisting of ½ consis	to assure food was served at a for client #6. prescribed. For in the home on 6/10/25 at as observed with a deep dish consisted of his dinner meal a baked chicken, ½ cup of collard greens, 8 oz water tinued observation revealed we some chunks of chicken und chicken. Further a client #6 to refuse his meal taff A presented his meal und portions not processed by as prescribed. If client 6#'s physician's order evealed a diet order istency diet. with the qualified intellectual hal (QIDP) confirmed both ent. Further interview with both clients' diet orders	W 474				