DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/12/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G249	A. BUILDING _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY ANGELS SERVICES-MCAULEY RESIDENCES	MCAULEY CIRCLE BELMONT, NC 28012

(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 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure clients in Belhaven had the right to personal possessions. The finding is: Observations throughout survey 6/3-4/25 revealed three electric beard razors lying on the bathroom counter absent of labels to identify the client to whom they belonged. Further observation revealed four plastic bins attached to the counter wall that were labeled with specific client names that could have been the electric razor cubbies; however, there were four named cubbies and three electric razors on the counter. Continued observation on 6/4/25 revealed the three electric beard razors to be lying on the bathroom counter, plugged and charging. Interview with the ICF Program Director (ICF-PD) on 6/4/25 verified the electric beard razors belonged to the male clients. Continued interview with the ICF-PD revealed the electric beard razors should have been properly labeled and stored.	W 137	This standard will be met by Policy #410 (Personal Property and Clothing) to be updated to include a process for labeling personal property and care items by June 25th,2025 and reviewed in the Continuous Quality Improvement Committee. The process will include a revision to the current inventory form (incoming clothing/personal items) to include a process of labeling and the distribution of personal items. The process will identify staff members responsible for labeling the personal belongings (such as the QP) prior to the distribution of personal belongings such as the resident's razors. To ensure continuous monitoring, recommendations are made to update the lead-to-lead checklist monitoring tool. The monitoring tool (Lead to Lead) checklist will be revised to include monitoring of the residents' personal belongings (razors and any other personal care items) to ensure proper labeling and storage. The tool will be updated by June 25th 2025. Training will be completed with the assigned (staff) by June 30,2025.	By 6/25/2025 By 6/25/2025 By 6/30/2025
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.	W 340	RECEIVED JUN 23 2025 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kerri C Massey | TITLE: President/CEO | (X6) DATE: 6/17/25

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.

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W 340	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained in health methods relative to medication administration for 1 of 6 clients observed during medication administration (#6). The finding is: Observation in the group home on 6/4/25 at 7:45 AM revealed a Belhaven med technician (BMT) to gather and prepare client #6's medication to be crushed to administer via her G-Tube. Continued observation revealed client #6 to be out of her Vitamin D3 2000 IU tablet. Further observations revealed the BMT to phone a nurse to request permission to take a Vitamin D3 from another Belhaven client to administer to client #6. Additional observation revealed the BMT to administer the borrowed Vitamin D3 to client #6 via G-Tube with all other medications. Review of records for client #6 on 6/4/25 revealed physician orders dated 6/4/2025. Review of the 6/4/2025 physician orders revealed medications to administer at 8:00 AM to be Aycacen 1/35-tab, Antacid Chew 1000 MG, Baclofen 20MG tab, Carbamazepine ER 200 MG tab, Diazepam 2 MG tab, Gabapentin 400 MG tab, Lactulose Sol 10 M/15, Multi-Vitamin Liquid 51 ML, VSL #3 112.5 BIL and Vitamin D3 2000 IU tab. Interview with the ICF Program Director (ICF-PD) on 6/4/25 verified the physician orders dated 6/4/2025 to be current. Continued Interview with the ICF-PD revealed that the med technician should never take another person's medication to use for a client; they should notify nursing, place a new prescription order and wait for the new prescription.	W 340	This standard will be met by written communication sent out to both licensed and unlicensed medication administration staff reviewing the process to address medication doses missing for residents by 6/16/25. Policy # 306 revision completed by 6/16/25 to clarify when medications can be shared with other residents to prevent Level 2 incident medical events. These include: cardiac and seizure medications and those that may be impacted by therapeutic drug levels,should there be a delay in administration. Policy #306 attached to POC. Training to be completed with Licensed nursing staff by 6/19/25 on the medication administration policy change. Training to be completed with non-licensed medication administrative staff by 6/26/25 on the medication administration policy change.	6/16/2025 6/16/2025 By 6/19/2025 By 6/26/2025

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W 340	Continued From page 2 Interview with the acting Director of Nursing (DON) on 6/4/2025 revealed the BMT is trained to administer medications. Further interview with the DON revealed the BMT should have followed procedure in notifying the nurse supervisor of the medication being out and place a new order for a refill; the client can take missed dose when the medication arrives. Continued interview with the DON revealed the BMT should never use another client's medication.	W 340		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals 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 biologicals were secured appropriately as required for 1 of 6 sample clients (#5) in Pinehaven Home. The finding is: Observations in the group home from 6/3/25-6/4/25 revealed the hallway bathroom to contain prescribed anti dandruff shampoo and two bottles of Cerave skin moisturizer located on the shelf. Continued observations revealed the prescribed shampoo and skin moisturizer belonging to client #5. Interview on 6/4/25 with first shift lead staff confirmed the prescribed bottles of shampoo and skin moisturizer belonged to client #5. Further interview with lead staff revealed that the items are left in the bathroom overnight and returned to the medication room following the completion of client #5's shower in the AM. Continued interview revealed the bottles are empty and the client no	W 382	This standard will be met by; Medical Director was contacted to confirm that over the counter personal care items could be discontinued as ordered by 6/9/25 and provided as part of their personal care supplies if that item was not actually medically necessary and was part of their standard personal care routine. Bathrooms were inspected to confirm no additional medically ordered supplies were incorrectly present by 6/9/25. Monthly Medication Room Audit tool updated by 6/16/25 to include inspection of bathrooms to identify any medications improperly stored. Tool attached to POC. Training to be completed with Licensed nursing staff by 6/19/25 on medication room audit tool revision and proper storage of medically prescribed medications and treatments. Training to be completed with non-licensed medication administrative staff by 6/26/25 on medication room audit tool revision and proper storage of medically prescribed medications and treatments.	6/9/2025 6/16/2025 By 6/19/2025 By 6/26/2025

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W 382	Continued From page 3 longer receives the anti dandruff shampoo as it was replaced with selsun blue shampoo. Subsequent interview with the lead staff confirmed by observation revealed staff to discard the prescribed shampoo and skin moisturizers into the bathroom trash can. Interview on 6/4/25 with the acting Director of Nursing (DON) confirmed client #5's prescribed medicated shampoo and skin moisturizer. Further interview with the DON confirmed that the client's medicated shampoo and skin moisturizers should be kept secured in the medication room when not being administered. Continued interview with the DON revealed the disposal of the prescribed bottles should have not been thrown into the trash can.	W 382		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review, and interview the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This potentially affected 5 of 5 clients (#1, #2, #3, #4, and #5) in Pinehaven Home. The finding is: Observations in the group home on 6/4/25 at 7:43 AM revealed the first shift lead staff to enter the kitchen to retrieve plates, cups and utensils from the kitchen cabinets. Further observations at 7:45 AM revealed client #7 to set his place at the table	W 454		

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W 454	Continued From page 4 following verbal prompts from the lead staff. Continued observations revealed the lead staff to set the remainder of the table. Subsequent observations between 8:05 AM to 8:18 AM revealed clients #1, #2, #3, #4, and #5 prompted and escorted to wash their hands. Subsequent observations revealed all clients to sit at the table to participate in their breakfast meal. At no point during observations before the breakfast meal did staff wipe the dining table or wash her hands before setting the table. Interview on 6/4/25 with the acting Director of Nursing (DON) and ICF Program Director (ICF-PD) revealed prior to setting the table, staff should have wiped the table. Further interview with the DON revealed staff should have washed her hands before setting the table.	W 454	This standard will be met by retraining staff to ensure prevention of cross contamination: • Updates to the New Hire Orientation training material course (Oral Feeding) to include specifics as it relates to ensuring proper infection control, while sanitizing the area, preparing a meal and the preparation of the resident's table. Recommendations to the New Hire Training Material to be completed by 6.25.2025 and reviewed in the Continuous Quality Assurance Committee. •Training to all identified staff that prepare and set the table for meals- Provide training as it relates to (Meal Preparation and Infection Control) will be provided at the next Residential Leadership Team Meeting, which is scheduled for June 30th, 2025. The training will be made up and completed for any missing staff by July 7th 2025. • The team (Program and the Dietary Coordinator) will work together to create a tool for the "assigned" leads for Meal Preparation and Infection Control- to be added to the Lead competency checklist- To be completed by June 30th 2025 and reviewed at the next Residential Leadership Meeting	By 6/25/2025 6/30/2025 & 7/7/2025 6/30/2025