

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

PRINTED: 06/23/2025  
FORM APPROVED  
OMB NO. 0938-0391

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

**HEATHCROFT**

STREET ADDRESS, CITY, STATE, ZIP CODE

**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
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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 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 125 The facility will ensure the rights of all clients is protected, providing each client with the opportunity for personal privacy.

To prevent further occurrence:

A. QIDP will educate all staff on client rights for client #5, and all clients in the home to ensure all clients have the right to privacy during treatment and care of personal needs.

B. QIDP will ensure incontinence pad is removed from the home in relation to privacy during personal care for client #5.

7/18/2025

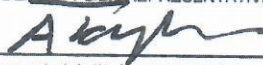
**RECEIVED**

**JUL 01 2025**

**DHSR-MH Licensure Sect**

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

Andrew Taylor



TITLE

Program Manager

(X6) DATE

06/27/2025

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.



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PROVIDER'S PLAN OF CORRECTION  
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DEFICIENCY)

(X5)  
COMPLETION  
DATE

W 249 Continued From page 1

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

The facility will implement prescribed adaptive equipment for all clients to includes client (#2 and #3) and other devices identified by the interdisciplinary team.

To prevent further occurrence:

A. QIDP will ensure prescribed adaptive equipment for all clients to includes clients #2 and #3 are available.

B. QIDP will educate all staff on all client's adaptive equipment's to includes client #2 and #3.

C. QIDP and Site Supervisor will complete weekly mealtime observation and document findings on observation form.

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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)

W 382

The facility must keep all drugs and biologicals



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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

W 382 The facility will ensure all medications are secured, lock and not leaving client unattended in the open unlocked medication cabinet. To ensure needs are met. Nurse will educate all staff on the importance of securing medications, procedure regarding medication keys and not leaving client unattended in the open unlocked medication cabinet.

To prevent further occurrence: Nurse and Site Supervisor will complete medication observation in the home weekly and document on medication observation form.

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medication is being administered to clients.

W 382