STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G116	A. BUILDING _____ B. WING _____	R 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST MAIN STREET FACILITY-CARRBORO	**1003 W MAIN STREET CARRBORO, NC 27510**

(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 000	INITIAL COMMENTS A revisit was conducted on 8/13/2025 for all previous deficiencies cited on 5/28/2025. Some of the deficiencies were corrected with new evidence of non-compliance found.	W 000		
{W 331}	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the nurse failed to ensure that health complaints were evaluated and treated for 1 of 4 audit clients (#5). The finding is: Record review on 5/28/25 revealed a 3/11/25 T-log note where client #5 complained of right foot/big toe pain and it appeared her toenails needed to be cut. On 5/1/25, client #5 was given ice to apply to her right foot after complaining of pain. On 5/2/25, client #5 reported she stubbed her toe on the sidewalk and complained of foot pain. On 5/7/25, client #5 saw a doctor after a fall and was sent to the emergency department. The scans were taken of her head, cervical spine and right wrist, but her foot was not examined. Her pain was treated with a medication. The interview on 5/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the nurse "probably should have" made a recommendation of how to handle client #5's complaints of foot pain, after reviewing the T-logs on 3/12/25 and 5/2/25. During a revisit on 8/13/25, review of the therapeutic log (T-Log) note for a medical	{W 331}		

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 331}	Continued From page 1	{W 331}		

incident for client #6 revealed treatment at the emergency room. The T-Log written by the Director on 7/28/25 at 5:40pm revealed client #6 fell when getting off of the recumbent bike in the home. The Director was in the home during the fall and discovered client #6 on the floor and it appeared he hit the coffee table, resulting in a cut on the left side of his head. Staff attempted first aid but could not stop the cut from bleeding. Client #6 was transported to the emergency room where he received 4 staples in his head. The Director noted he did not complain of a headache or any head injury and would be monitored for changes in symptoms, i.e., vomiting, dizziness, difficulty walking, or talking, any new or worsening symptoms.

Record review on 8/13/25 of an electronic record of all staff who were notified of client #6's fall on 7/28/25 revealed the nurse acknowledged she reviewed the T-Log note. There was no other correspondence from the nurse that she was further involved in his head injury.

Interview on 8/13/25 with the Home Manager revealed the nurse comes to the home monthly to audit the Medication Administration Records (MAR), when the clients are not home. The HM did not know of any recent exam by the nurse for client #6.

Interview on 8/13/25 with the Director acknowledged she made the decision to send client #6 out to the emergency room on 7/28/25 and did not think it was necessary to speak to the nurse for authorization. The Director revealed there were symptoms they monitored after client #6's head injury but none of the observations were recorded in his medical chart. The Director

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{W 331}	Continued From page 2 was unaware if the nurse was monitoring client #6's neurological status and how long they needed to monitor his symptoms after a head injury.	{W 331}		