STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	534 COUNTRY LANE HOLLY SPRINGS, NC 27540

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure clients were afforded privacy. This affected 1 of 3 audit clients (#3). The finding is: Observations in the home on 12/29/25 at 3:30pm client #6 was in the bathroom on the toilet with the door closed. Client #3 walked into the bathroom without knocking while client #6 was sitting on the toilet. Client #3 walked out of the bathroom and went to his bedroom. Further observation in the home at 3:45pm, client #3 walked into the bathroom without knocking while client #6 continued to sit on the toilet. Record review on 12/30/25 of client #3's community home life assessment dated 5/1/25 revealed client #3 need verbal cues to knock on doors before entering. Interview on 12/30/25 with the area supervisor confirmed that client #3 needs verbal cues to knock on closed doors before entering.	W 130		
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. This STANDARD is not met as evidenced by:	W 340		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING _____ B. WING _____	12/30/2025

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(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 340	Continued From page 1 Based on observation s and interview, the facility failed to ensure staff were sufficiently trained on appropriate protective and preventive health and hygiene methods for client care. This affected 1 of 3 audit clients (#3). The finding is: Observations of medication administration in the home on 12/30/25 at 6:00am, client #3 punched out a pill and the pill fell beside the cup on the wooden cup holder that was not cleaned between usage. The medication technician picked up the pill and placed the pill in the pill cup with the other medications. Client #3 ingested the pills in the medication cup. Interview on 12/30/25 with the area supervisor confirmed that the nurse should have been called and the pill disposed. Interview on 12/30/25 with the registered nurse confirmed that client #3 should not have ingested the pill that fell on the wooden cup holder.	W 340		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) 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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff were sufficiently trained in documentation of seizure protocol. This affected 1 of 3 audit clients (#3).	W 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING _____ B. WING _____	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	534 COUNTRY LANE HOLLY SPRINGS, NC 27540

(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 342	Continued From page 2 The finding is: Review on 12/30/25 of monthly nursing notes revealed no seizure in the month of July 2025, 1 seizure in the month of August on 8/17/25. There was no evidence of any seizure reports being completed. Review on 12/30/25 of qualified intellectual disabilities professional (QIDP) monthly notes revealed no seizure in the month of July and August 2025. Review on 12/30/25 of the neurology appointment 11/17/25 revealed no report of any seizure activity. Interview on 12/30/25 the area supervisor revealed there has been a change in staff and she was unsure if seizure reports were completed. Interview on 12/30/25 with the registered nurse confirmed seizure reports should be completed each time a seizure occurs.	W 342		