

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2026
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NAME OF PROVIDER OR SUPPLIER WILMINGTON ROAD GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 800 WILMINGTON ROAD FAYETTEVILLE, NC 28304
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E 030	<p>Names and Contact Information CFR(s): 483.475(c)(1)</p> <p>§403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).</p> <p>[(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:]</p> <p>(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.</p> <p>*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.</p> <p>*[For RNHCI at §403.748(c):] The communication plan must include all of the following:</p>	E 030		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 030	<p>Continued From page 1</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Next of kin, guardian, or custodian.</p> <p>(iv) Other RNHCIs.</p> <p>(v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Hospice employees.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Other hospices.</p> <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Volunteers.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following:</p>	E 030			

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E 030	Continued From page 2 (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop a system to identify clients and guardians in their emergency preparedness (EP) plan. This affected 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 1/6/26 of the facility's EP plan dated March 2025 revealed there were no details that listed updated information of all clients and guardian information. Interview on 1/6/26 with the Home Supervisor confirmed the information in the EP plan did not have current information for all the clients in the home.	E 030			
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 249			

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W 249	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of adaptive equipment implementation. This affected 1 of 4 audit clients (#2). The finding is: Observations on 1/5/26 at 5:30pm in the kitchen at the dining table in the home, revealed client #2 was eating with a regular teaspoon. Further observation on 1/6/26 at 7:30am revealed client #2 ate her breakfast with a teaspoon, with her cream of wheat in a individual bowl and her apple sauce in a separate individual bowl. Review on 1/6/26 of client #2's Occupational Therapy assessment dated 11/5/24 recommends using a small maroon spoon an inner lip plate during meals and snacks. Interview on 1/6/26 staff B stated client #2 was allowed to use a regular spoon and individual bowls during meals.	W 249			
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: Based on observations, recored reviews and interviews, the facility failed to ensure staff were	W 340			

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W 340	<p>Continued From page 4</p> <p>sufficiently trained to implement appropriate health and hygiene methods. This affected 2 of 4 audit clients (#4 and #5). The findings are:</p> <p>A. Observations in the home throughout the survey on 1/5-6/26, client #4's fingernails were noted to be long extending past the nail bed.</p> <p>Record review on 1/6/26 of client #4's adaptive behavior inventory (ABI) dated 10/28/25 "trims nails" rated 1 = "no independence, cannot perform any portion of the behavior independently".</p> <p>B. Observations in the home throughout the survey on 1/5-6/26, client #5's fingernails were noted to be long extending past the nail bed.</p> <p>Record review on 1/6/26 of client #5's adaptive behavior inventory (ABI) dated 10/24/25 "trims nails" rated 1 = "no independence, cannot perform any portion of the behavior independently".</p> <p>Interview on 1/6/26 with staff A revealed clients nails should be trimmed weekly or as needed and documented in the program book.</p> <p>Interview on 1/6/26 the facility nurse revealed nails should be trimmed weekly or as needed. There is no documentation to show when nails are trimmed.</p>	W 340			
W 454	<p>INFECTION CONTROL</p> <p>CFR(s): 483.470(l)(1)</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p>	W 454			

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W 454	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations and interviews 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 1 of 4 clients (#2). The finding is: Observations in the home on 1/6/26 at 7:30am staff C had wiped the table with a napkin, pulled the plastic from a dish and assisting another client with pouring a drink. Staff C then opened client #2's cup, removed the insert with her hand. She touched the inside of the insert poured milk into the cup then placed the insert into the cup. Client #2 picked up the cup and began to drink out of the cup. Interview on 1/6/26, with staff C revealed she should have replaced the insert with a glove on her hand. Interview on 1/6/26 with the facility nurse confirmed staff C should not have touched the insert in client #2's Provale cup.	W 454			
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 4 audit clients (#2) received their specially prescribed diet	W 460			

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W 460	Continued From page 6 as indicated. The finding is: Observations in the facility on 1/5/26 during dinner at 5:30pm revealed client #2 was served whole green beans. Further observations during breakfast on 1/6/26, client #2 was served a ground english muffin. Record review on 1/6/26 of client #2 nutritional evaluation revealed puree diet, regular calorie. Interview on 1/6/26 with the qualified intellectual disabilities professional confirmed client #2 should receive a pureed diet.	W 460			